S. HRG. 98-529

CONTROLLING HEALTH CARE COSTS: STATE, LOCAL, AND PRIVATE SECTOR INITIATIVES

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

FIRST SESSION

WASHINGTON, D.C.

OCTOBER 26, 1983

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE
28-420 O WASHINGTON : 1984

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402

S141-5

SPECIAL COMMITTEE ON AGING

JOHN HEINZ, Pennsylvania, *Chairman*

PETE V. DOMENICI, New Mexico
CHARLES H. PERCY, Illinois
NANCY LANDON KASSEBAUM, Kansas
WILLIAM S. COHEN, Maine
LARRY PRESSLER, South Dakota
CHARLES E. GRASSLEY, Iowa
PETE WILSON, California

JOHN GLENN, Ohio
LAWTON CHILES, Florida
JOHN MELCHER, Montana
DAVID PRYOR, Arkansas
BILL BRADLEY, New Jersey
QUENTIN N. BURDICK, North Dakota
CHRISTOPHER J. DODD, Connecticut

John C. Rother, *Staff Director and Chief Counsel*
Diane Lifsey, *Minority Staff Director*
Robin L. Kropf, *Chief Clerk*

CONTENTS

Page

Opening statement by Senator John Heinz, chairman ... 1
Statement by Senator John Glenn ... 2
Statement by Senator Lawton Chiles ... 22
Statement by Senator Charles H. Percy ... 23

CHRONOLOGICAL LIST OF WITNESSES

Taylor, Humphrey, president, Louis Harris & Associates, Inc., New York, N.Y ... 5
Schramm, Carl J., Ph. D., J.D., director and associate professor, Center for Hospital Finance and Management, Johns Hopkins University, Baltimore, Md ... 30
Morone, James A., Ph. D., assistant professor of political science, Brown University, Providence, R.I ... 38
Crosier, John D., Waltham, Mass., executive director, Massachusetts Business Roundtable, Inc ... 44
Sloan, Frank A., Ph. D., executive director, Health Policy Center, Vanderbilt University, Nashville, Tenn ... 47
Etheredge, Lynn, scholar-in-residence, Center for Health Policy Studies, Georgetown University, Washington, D.C ... 64
Butler, Leona M., Oakland, Calif., director, provider contracting and public affairs, Blue Cross of California ... 69
Cook, Jack, Ph. D., president, Health Systems Research, Inc., Boston, Mass ... 76
Schaeffer, Leonard D., president, Group Health, Inc., Minneapolis, Minn ... 78

APPENDIX

Statement of Deborah Chollet, Ph. D., research associate, Employee Benefit Research Institute, Washington, D.C ... 97

CONTROLLING HEALTH CARE COSTS: STATE, LOCAL, AND PRIVATE SECTOR INITIATIVES

WEDNESDAY, OCTOBER 26, 1983

U.S. Senate,
Special Committee on Aging,
Washington, D.C.

The committee met, pursuant to notice, at 9 a.m., in room 562, Dirksen Senate Office Building, Hon. John Heinz, chairman, presiding.

Present: Senators Heinz, Percy, Grassley, Glenn, Chiles, Melcher, Bradley, and Burdick.

Also present: John C. Rother, staff director and chief counsel; Diane Lifsey, minority staff director; Barbara Krimgold, professional staff member; Isabelle Claxton, communications director; Jane Jeter, minority professional staff member; Robin Kropf, chief clerk; Nancy Newman, assistant chief clerk; and Angela Thimis, hearing clerk.

OPENING STATEMENT BY SENATOR JOHN HEINZ, CHAIRMAN

Chairman Heinz. Good morning, ladies and gentlemen. Today, the Senate Special Committee on Aging continues its series of hearings on the future of medicare.

The financial illnesses facing medicare was the subject of our hearings last April, and I think are well known. The disease that afflicts medicare, which is health care costs rising at three times the rate of overall inflation, is not limited to medicare alone. The excessive growth rates of health care costs are spreading systematically like a cancerous growth through the entire health care sector. They threaten the health and productivity of other segments of our economy. To control medicare costs over the long term, it now appears that we may need to restrain health care costs across the board. If we do not, not only will medicare face bankruptcy by the end of this decade, but by the year 2000, annual medical care costs in 1983—not inflated, but in 1983 dollars—will average over $2,500 a year for every man, woman, and child in America, or a full $10,000 per year in today's dollars, for the average family of four.

Voluntary Federal health planning efforts have failed, and the evidence is that the so-called competitive approaches—tried to date—cannot achieve the reductions in health care costs on the scale or within the time frame that is necessary. The new prospective payment system for hospitals based on diagnostic related groups, or DRG's sets limits on medicare unit costs. But it is still unclear whether those medicare restraints will reduce total health care costs or like a balloon squeezed at one end—force the economic pressures to another area, thereby increasing costs for nonmedicare patients.

Our witnesses today have been asked how to make delivery of health care more cost effective. These initiatives include, most prominently, State systems which set hospital rates, not just for public health programs, but for all payers. The extent to which these all-payer systems have effectively capped health care cost increases and achieved large-scale savings is of vital interest to the committee, as is the question of the national applicability of a system tailored to the political and economic circumstances of a particular State. Today, I am releasing a committee print which outlines, State by State, these health cost-containment programs.

Since the system that is quality deficient, no matter how cost effective, is not an acceptable system, we also want to find out how the efforts that will be described affect the quality of care actually received by the patient. The committee wants to assess, in addition, the impact of locally based efforts of organizing and managing delivery of health care as a means of curtailing costs.

There is no doubt in my mind that we are approaching a cost crisis in medicare and our entire health care system. If we have to ask the American people to make sacrifices to preserve the basic benefits of the system we have—and it is unlikely we will find any effective solution without some additional sacrifices by somebody—then we must insure that the existing system is as efficient as we can make it, or the people we serve will never be convinced that other steps, especially those that may demand an apparent tradeoff at their expense, are both necessary and justified.

Unfortunately, what we lack most in our efforts to rescue health care from its inflation spiral is not ideas. We have plenty of those. But we do not have very much time. In 5 years, by 1988, medicare will be bankrupt. The scale of the problem is enormous, even in comparison to the social security deficit which we faced, and to a large extent solved last spring.

In today's witnesses, we have a profound reserve of experience and know-how that can be invaluable in our race to beat the clock. So we look forward to their testimony.

Before I call on our witnesses, I would like to recognize the ranking member of this committee, Senator John Glenn of Ohio, my friend and colleague.

STATEMENT BY SENATOR JOHN GLENN

Senator **Glenn**. Thank you very much, Mr. Chairman. That was an excellent statement concerning our problem. I agree with you.

Later in this decade, we face a funding crisis in medicare that could outweigh the recent social security trust fund debate. Insuring the solvency of the health insurance program will require us to address the all-encompassing issue of double-digit inflation in our health care industry. Solvency measures will be hard to fashion since they cannot be aimed solely at medicare, but must be directed at the financing and delivery of medical care overall in this country. While we want inflation reined in, we do not want to see the quality of medical care sacrificed.

Success in developing effective health care cost-containment programs will depend on the cooperation—and a lot of cooperation—of the Federal Government with the States, business, labor, insurance companies, and health care providers. It will involve experimenting with combinations of different measures, including both regulation and increased competition. We have already taken some positive steps in encouraging States to pursue their own cost-containment initiatives in medical care, and I would like to see an even greater incentives program established for the States.

In considering options to reduce health care cost inflation, we must carefully weigh establishing reasonable reimbursement levels for hospital and physician care as well as for new technologies. The impact of the new medicare prospective payment system may also play a valuable role as a model for future cost-reduction efforts. After careful assessment, we may have to consider Federal cost-containment legislation beyond medicare to include other hospital payers in order to make health care delivery more efficient.

As part of any true cost-containment strategy, we must continue to look for ways to lessen the utilization of expensive, acute medical care. Enrollment in cost-saving competitive programs, such as HMO's and PPO's, should be encouraged. Noninstitutional care programs such as home health should be expanded. Also, we must recognize the impact of lifestyle on health by providing adequate nutritional and other social service support for those in need.

Medicare solvency is a must, but it is difficult to see how we can require larger out-of-pocket payments from beneficiaries as part of any solution. The notion that elderly citizens are somehow insulated by medicare from the high cost of health care is nonsense. Older Americans are burdened by the gaps in medicare coverage, with the program paying less than half the cost of their medical bills. Medical care costs not paid for by medicare equal about 20 percent of the average per capita income for an individual over age 65, about the same share of income that health care cost consumers prior to the enactment of medicare in 1965.

No American chooses to become sick, but I know many who live in fear of what will happen—and how much it will cost—should they become ill. While we do not yet have all the answers to controlling health care cost inflation, we do not want to scare older Americans, or their children, with the prospect of medicare insolvency in the way Americans were scared prior to the passage of social security solvency legislation earlier this year.

I am confident that working closely with the States, the private sector, medical care providers, and health care consumers, we can find the right steps to take to control health care costs and to improve the delivery of medical care in our country. I look forward to hearing from today's witnesses, and I am sure the information they provide about initiatives to control health care costs will be very helpful.

Thank you, Mr. Chairman.

Chairman HEINZ. Thank you, Senator Glenn.

Senator Burdick, do you have an opening statement you would like to make?

Senator BURDICK. No.

Chairman HEINZ. Before hearing from our witnesses, I want to put Senator John Melcher's statement into the record. Unfortunately, he had a prior commitment and had to leave. Also, Senator Nancy Kassebaum has submitted a statement for the record. Without objection, these statements will be inserted into the record at this time.

[The statements of Senators Melcher and Kassebaum follow:]

STATEMENT OF SENATOR JOHN MELCHER

This hearing by our Senate Special Committee on Aging is a welcome and encouraging step as Congress takes on the difficult and complex responsibility of trying to control health care costs skyrocketing at a rate almost triple the rate of general inflation. Our careful examination of State, local, and private sector initiatives that are attempting to put a lid on these costs should give us an important base of information for congressional action.

I recently sent out a statewide newsletter to my constituents in Montana on the subject of the Federal budget. A reply card was enclosed with a checklist for them to note issue areas that most concerned them. Controlling health care costs was the second most frequent item checked. Clearly, this is a pervasive worry, not only to the elderly, but to people in general. Many expressed shock, dismay, and anger at seemingly illogical physician fees, hospital charges, and dramatic increases in insurance premiums.

I believe quality health care must be available at a cost we can afford. Neither private insurance coverage nor the Federal Government can stand this continual double-digit escalation of costs. Congress must get costs down.

STATEMENT OF SENATOR NANCY LANDON KASSEBAUM

The need to restrain the growth of health care costs is today greater than ever. The 17-percent increase in health cost inflation registered in 1982 comes on top of a decade of steady increases. This untrammeled growth continues to shock a Nation which, buffeted by unrelenting price escalations throughout the economy during the late 1970's, had almost resigned itself to double-digit inflation as a fact of economic life. The good news of the 1980's is that we are well on our way toward driving a stake into the heart of an inflationary force which has threatened our standard of living and opportunity for growth. Yet, we must continue to temper this good news with the acknowledgment that our health care system remains virtually oblivious to this positive trend.

I, therefore, commend Chairman Heinz for his initiative in holding this timely hearing on State, local, and private sector efforts in the area of health cost containment. Traveling throughout Kansas over the recent Columbus Day recess, I found that health care costs ranked at the top of the list of concerns expressed by my elderly constituents. The depth of this concern is further underscored by the fact that health care emerged as the No. 1 concern identified by older Kansans during local preparations for the Silver-Haired Legislature which met in Topeka earlier this month. Of the 23 measures selected for consideration by the legislature, nearly half dealt with the cost, quality, and availability of health services.

I know this phenomenon is not confined to my own State borders. Older persons are fully aware of the implications which the unrestrained growth of health care costs hold for the medicare program. Since its enactment in 1965, medicare has offered a sense of security to individuals who recognize that the aging process inevitably takes its toll in the form of higher medical bills. By offering some guarantee of protection against these additional expenses, medicare has been important, not only for the actual services it provides, but also for the worries it alleviates among those who may require these services in the future.

Consequently, projections that the medicare trust fund will be depleted by 1990, offer a terrifying specter to older persons of a health care system beyond the means of all but a few. The congressional response to this situation will undoubtedly mean some revisions in the medicare program itself. Yet, it is shortsighted to believe that a response confined only to medicare will be either equitable or effective. Of the projected 13.2 percent increase in hospital costs attributable to medicare, only 2.2 percentage points are due to the aging of the population. The remainder is accounted for by the rising cost of care.

At the Federal level, we have begun the process of change with the new hospital prospective payment system under medicare which went into operation on October 1. Our experience with this program over its 3-year transitional period will lay the foundation for future innovations. My home State of Kansas is joining many other States in the endeavor to control other health care costs. Effective July 1 of this year, the Kansas medicaid program abandoned its cost-based reimbursement system for hospitals in favor of a per diem-based prospective payment program for inpatient services.

In addition, January 1, 1984, will mark the beginning of the competitive allowance program (CAP) established by Blue Cross/Blue Shield of Kansas. The CAP program will reimburse hospitals prospectively on a diagnosis related group basis. Participating physicians will be reimbursed on the basis of a maximum allowable payment per procedure, which will be accepted as payment in full. One hundred percent of acute-care hospitals, 87 percent of physicians, and 72 percent of dentists in the plan area have agreed to participate in CAP. Blue Cross/Blue Shield of Kansas, which enrolls approximately 38 percent of the population, initiated this program after seeing premium increases average 24 percent a year over a 4-year period.

I will follow developments at the Federal level and in Kansas with great interest. Today, I am particularly eager to learn more about the experiences of those States, localities, and private organizations which have taken the lead in rethinking traditional means for the financing and delivery of health care. These entities operate as an expeditionary force, charting the perils and promises which lie ahead, as the Federal Government, and other States, approach this complex and troubling issue. Clearly, we have much to learn.

Chairman HEINZ. Our first witness is Humphrey Taylor, president of Louis Harris & Associates.

Mr. Taylor, I understand you have both a visual presentation as well as oral.

STATEMENT OF HUMPHREY TAYLOR, PRESIDENT, LOUIS HARRIS & ASSOCIATES, INC., NEW YORK, N.Y.

Mr. TAYLOR. Senator, thank you. I am honored to be here and grateful for this opportunity to tell you very briefly about a very important survey which we have just completed for the Equitable Life Assurance Co. of America. The survey deals specifically with the issue of health care cost containment in both the public and private sectors.

In the interest of brevity, I hope you will forgive me if I dispense with the description of the methodology and go to a small description of the highlights of the survey. I think we need some of the lights down a bit to see the charts properly.

Chairman HEINZ. Can we prevail upon the television people to turn their lights out for a moment.

Mr. TAYLOR. As you can see from the next chart, we interviewed a wide variety of different people. This was not just a survey of the elderly population. We surveyed the elected leaders, physician organizations, hospital administrators, senior health insurance corporate executives, and union leaders.

I think a good place to start, if I may pick just a few of the highlights, is with the overall views of the American people toward the health care system as it is today. And as you can see, the American public is far from satisfied with the status quo.

Table 1-1

OVERALL VIEWS OF THE AMERICAN HEALTH CARE SYSTEM: THE PUBLIC AND PROFESSIONALS COMPARED

Q. Which of the following statements comes closest to expressing your overall view of the American health care system?

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
On the whole the health care system works pretty well, and only minor changes are necessary to make it work better	21	68	41	16	12	19
There are some good things in our health care system, but fundamental changes are needed to make it work better	50	32	56	80	79	69
The American health care system has so much wrong with it that we need to completely rebuild it	25	-	2	4	8	12
Not sure	4	-	1	-	1	-

Indeed, only 21 percent of all adult Americans believe that on the whole, the health care system works pretty well and that only minor changes are necessary. Fully 50 percent believe that, while there are some good things in the system, fundamental changes are needed to make it better, while a quarter think that the system has so much wrong with it that we need to completely rebuild it.

I should add that the majority of the hospital administrators, insurance executives, corporate benefit officers, and union leaders, all endorsed the second of these three choices, that fundamental changes are needed. A majority of only one group endorsed the status quo, 50 percent of physician leaders believe that only minor changes are necessary to improve our system.

Next we asked people to tell us in their own words, what would be their first priority if they could make one change in our system.

Table 1-6
SUGGESTED CHANGES IN THE U.S. HEALTH CARE SYSTEM

Base: Public cross section

Q. If there were *one* change you could make in the health care system in the United States, what would it be?

No. of Respondents	1501
	%
Cost-Related Changes (Total)	**23**
Control/limit costs	12
Lower hospital costs	5
Reduce doctors' charges	4
Government should cover health care/insurance costs	2
Make it less expensive (nonspecific)	-
Access-Related Changes (Total)	**24**
More/better care for the elderly, more inclusive Medicare	11
Assure availability of equal quality care for all	5
For those who can't afford it, cut costs/provide financial support	5
Need better insurance coverage, reevaluate coverage	3
Other Suggested Changes[2]	
Socialized Medicine, national health service	8
Less impersonal doctor/patient relationship	3
Preventive medicine should be implemented/augmented	2
Eliminate waste/fraud/graft pilfering/handouts	2
Better hospitals — care, attitudes, integrity	2
Public education regarding medical programs and costs	2
More research, find cures	2
More doctors/students in medical schools	2

1 Source: *1980 Lou Harris Perspective: Healthcare*

2 Only specific suggestions mentioned by 2% or more of the sample are reported in this table.

As you can see, cost-related and access-related changes headed the list of public responses. Furthermore, I should add, that many of the responses relating to access dealt specifically with cost barriers, which it is believed, prevent elderly Americans and those of low incomes from obtaining access to care. Indeed, there is a widespread feeling that many do not have adequate access to care, a finding which other findings in our survey, tend to refute. Indeed, we find that the great majority of older Americans at the present time do have access to care, and that is largely due to the medicare system.

Now, one very important finding was that only 16 percent of all American adults say that they have ever, at any point in their lives, selected a doctor because his or her fees were lower than those of another doctor.

Table 1-14

SELECTION OF DOCTOR BECAUSE OF LOWER FEES

Base: Public cross section

Q. Other things being equal, have you ever selected a particular doctor because his or her fees were lower than another's, or haven't you?

		Health Status		Type of Health Care Coverage				
	Total	Excellent/ Good	Fair/ Poor	Through Work or Union	Medicare	Medicaid	Other	None
No. of Respondents	1501	1253	247	1016	300	94	687	75
	%	%	%	%	%	%	%	%
Yes, have selected	16	17	15	16	8	17	15	36
No, have not selected	83	82	84	83	91	80	84	64

I would like, if I could, to jump through a large part of the survey to what is in a sense the heart of the survey. And before I show you the charts, just a word of introduction.

What we did was just to do an extensive review of the literature of the various bills which are working their way or not working their way through the Congress, many proposals that have been made in both the private and public sector for health care containment. And we boiled these down to 24 specific policies. We asked each of the samples we interviewed two questions about these policies, how effective they thought they would be in controlling costs or discouraging the use of nonessential services, and how acceptable the policies would be to them personally, or in the case of special groups, such as professionals in the field.

Now, one finding which was true of the great majority of all these specific proposals is that there is a very high correlation between the acceptability and the perceived effectiveness of the different policies. When a policy is perceived to be effective, it is likely to be acceptable. Not always, but in most cases. And the more effective it is believed to be, the more likely it is to be acceptable.

Now, I would like to stress that we did not ask people whether they favored or opposed these policies, but whether they would be very acceptable, somewhat acceptable, or not very acceptable, or not at all acceptable. Given that most of the policies have somewhat disagreeable consequences for the public, or for providers, or for third-party payers, it seemed to us that the essential question was not what they would ideally like, but what they could accept and go along with. I think and hope that you will find these answers to the questions both surprising and encouraging.

9

Table 3-2

ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

Q. Would it be very acceptable, somewhat acceptable, not very acceptable, or not at all *acceptable to you* personally/as a professional in this field?

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
In the case of non-emergency surgery, requiring the patient to get a second opinion from another doctor to find out if the surgery is necessary						
Very acceptable	64	27	46	54	64	58
Somewhat acceptable	24	36	38	38	29	23
Not very/not at all acceptable	10	37	15	8	6	19
A system that encourages people to have tests and minor surgery done in clinics and doctors' offices rather than in hospitals						
Very acceptable	56	67	55	70	83	58
Somewhat acceptable	27	32	29	26	14	23
Not very/not at all acceptable	16	1	13	4	2	20
Insurance plans that offer incentives to people who practice health and safety procedures — such as non-smokers, seatbelt users, or those who are not overweight						
Very acceptable	52	75	63	56	45	46
Somewhat acceptable	28	22	29	34	34	38
Not very/not at all acceptable	18	2	7	8	20	12
Insurance plans that encourage the care and treatment of the chronically ill at home instead of in hospitals and nursing homes						
Very acceptable	46	66	60	62	57	46
Somewhat acceptable	32	25	31	34	36	38
Not very/not at all acceptable	20	7	8	4	8	12

Continued

Table 3-2 (Continued)

ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Preventing people in families where more than one person has employer-provided health insurance from filing more than one insurance claim for the same medical services						
Very acceptable	40	59	65	60	49	66
Somewhat acceptable	27	21	15	22	22	15
Not very/not at all acceptable	29	19	16	18	26	12
A system in which the fees paid to doctors and hospitals for treating all patients with particular types of diagnoses are fixed						
Very acceptable	37	6	27	32	26	38
Somewhat acceptable	39	26	44	52	50	35
Not very/not at all acceptable	21	67	27	16	23	19
Government price controls of doctors' and hospital fees						
Very acceptable	34	1	10	6	13	50
Somewhat acceptable	27	6	11	14	14	15
Not very/not at all acceptable	36	90	74	78	70	27
A system that discourages a hospital from having expensive equipment and specialists, if they are available at another hospital nearby						
Very acceptable	32	18	43	58	54	62
Somewhat acceptable	30	33	30	26	30	12
Not very/not at all acceptable	36	47	25	16	15	24
A system that encourages the use of nurse practitioners, midwives, and physicians' assistants rather than physicians						
Very acceptable	29	4	24	30	28	31
Somewhat acceptable	34	20	35	48	45	42
Not very/not at all acceptable	35	75	40	20	26	23

Continued

Table 3-2 (Continued)

ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Requiring employees to pay a part of their health insurance premiums						
Very acceptable	29	54	45	42	45	27
Somewhat acceptable	36	35	36	36	32	19
Not very/not at all acceptable	32	10	18	22	22	50
A health plan where, for a monthly fee paid in advance, you receive physicals, doctors' visits, and hospitalization no matter how often you use these services						
Very acceptable	29	6	23	32	25	35
Somewhat acceptable	32	31	43	38	42	42
Not very/not at all acceptable	36	61	33	30	33	23
Health insurance in which a patient selects a physician from a list of doctors who provide all basic medical care for a predetermined fee, and who also assume the responsibility for authorizing all services from specialists, labs, and hospitals for that patient						
Very acceptable	29	11	40	46	32	31
Somewhat acceptable	40	37	40	38	51	38
Not very/not at all acceptable	29	52	19	14	17	27
Limiting the use of expensive medical technology for patients who have virtually no hope of recovery						
Very acceptable	25	24	20	8	9	12
Somewhat acceptable	24	35	28	20	27	27
Not very/not at all acceptable	46	38	49	72	61	50

Continued

Table 3-2 (Continued)

ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Increasing the deductible — the costs that a patient must pay before the insurance plan starts to cover medical expenses — so that people become more cost-conscious when seeking medical services						
Very acceptable	24	58	41	46	56	27
Somewhat acceptable	34	31	38	42	34	38
Not very/not at all acceptable	39	10	20	12	10	35
Including only hospitals and doctors with lower prices in a health insurance plan, and excluding those that are more expensive						
Very acceptable	22	7	11	18	12	19
Somewhat acceptable	40	24	34	32	30	46
Not very/not at all acceptable	34	68	53	48	56	35
Health insurance in which patients who use physicians and hospitals selected by the plan pay a lower share of the cost of services than patients who choose doctors and hospitals not on the list						
Very acceptable	22	6	31	44	24	19
Somewhat acceptable	39	35	37	42	45	58
Not very/not at all acceptable	36	58	32	14	31	20
A system in which the patient has to obtain from the insurance company payment approval for specific expenses and length of hospitalization prior to nonemergency hospitalization						
Very acceptable	22	7	13	34	38	23
Somewhat acceptable	35	27	34	36	38	38
Not very/not at all acceptable	41	66	51	28	23	38

Continued

Table 3-2 (Continued)

ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Requiring patients to pay a greater part than they now pay of all their medical bills covered by their health insurance to encourage them to watch their medical expenses						
Very acceptable	19	48	33	42	49	19
Somewhat acceptable	33	34	43	40	36	27
Not very/not at all acceptable	46	17	22	18	14	46
Requiring employees whose employers pay large health insurance premiums for them to pay taxes on the portion of the premium that exceeds $840 for the individual and $2,100 for the family						
Very acceptable	14	25	20	-	4	12
Somewhat acceptable	25	37	31	18	16	8
Not very/not at all acceptable	56	36	43	82	78	77
Businesses and employers in particular cities or areas working together in health care coalitions to reduce costs						
Very acceptable	x	37	43	74	69	65
Somewhat acceptable	x	48	44	24	30	23
Not very/not at all acceptable	x	15	12	2	1	12
Utilization reviews conducted by third-party payers to discourage the use of expensive and/or inessential procedures						
Very acceptable	x	15	35	60	57	12
Somewhat acceptable	x	37	31	36	36	38
Not very/not at all acceptable	x	47	33	2	6	8

Continued

I would like to look first at proposed changes in health care coverage which are designed to reduce nonessential utilization by increasing the out-of-pocket cost of health care to patients.

And the fact that so many Americans are prepared to go along with policies of this type is, I think, not only a surprise, but an indication of the widespread concern of the American people, who clearly recognize that some fairly disagreeable remedies are necessary if health care costs are to be brought under control. As you can see, 65 percent of the American public told us that it would be somewhat acceptable to require employees to pay a part of their own health insurance program premiums.

Fifty-eight percent of respondents told us that it would be acceptable to increase the deductibles that they pay, and 52 percent are willing to increase copayments. Although, as you can see, almost half, 46 percent, of the American population are opposed to this.

One policy which most people regard as unacceptable is the proposal of the administration to tax the top end of the more expensive health insurance premiums. One reason we believe why this proposal is unacceptable to a 56-percent majority of the public is their view that it would not be effective, presumably because under this proposal there is nothing the individual employee can do in the way of reducing his or her utilization to avoid paying that tax. Changes in health insurance plans which provide a lower cost option to patients, usually with some built-in constraints, such as less freedom of choice of providers, and employers are widely believed to be effective in containing health care costs and are generally, though not universally, acceptable.

There is overwhelming acceptance of the concept of second opinions for nonemergency surgery. Indeed, only 10 percent regard this as unacceptable.

Fully 63 percent would be willing to accept a system that would encourage the use of nurse-practitioners, midwives, and physician assistants. However, as you can also see, the overwhelming majority of physician leaders, 75 percent of them, regard this proposal as unacceptable. However, hospital administrators are supportive by 59 to 40 percent.

Almost 7 out of every 10 Americans would be willing to accept a system which requires patients to select physicians from a list of doctors who provide basic medical care for a predetermined fee, and also assume the responsibility for authorizing other services of specialists, labs, and hospitals. This, however, is another proposal to which a majority, albeit a more modest one, of physician leaders are opposed.

A majority of the public and of hospital administrators regard a prepaid plan with a monthly fee, in return for which, patients receive all physicals, doctors' visits, and hospitalization as acceptable. This, of course, is that HMO concept. Here again, a majority of physician leaders think this proposal unacceptable.

Health insurance which would include only hospitals and doctors who charge lower prices and which would exclude those who charge higher prices is also acceptable to a majority of the public. However, this proposal is unacceptable to more than two out of every three physician leaders, and over half of all hospital administrators. A less stringent variant of this scheme in which patients can go outside a selected list of physicians and hospitals, where they would pay a higher cost for doing so, is acceptable not only to a majority of the public, but also in this case, to a majority of hospital administrators. This, of course, is a typical PPO. In light of what we have seen already, it is, I suppose, no surprise the majority of physician leaders oppose this concept also.

One proposal which is universally acceptable to a large majority of all the groups that we surveyed is a modification to health insurance plans to offer incentives to people who practice health and safety procedures, for example, nonsmokers, seatbelt users, or those who are not overweight. Only 18 percent of the public is opposed to this.

In light of the fact that most people recognize the necessity of—and I have not shown the data on that, but they do, they recognize the necessity of eliminating unnecessary hospitalization—it is not surprising that a majority of the public support most suggestions designed to achieve this. For example, only 16 percent do not think it acceptable to have a system that encourages people to have tests and minor surgery done in clinics and doctors' offices rather than in hospitals. I think it is noteworthy that this is acceptable, not only to the public, but also a majority of physicians and hospital administrators.

Another somewhat similar proposal is to modify insurance plans for the care and treatment of the clinically ill at home instead of in hospitals and nursing homes. Large majorities find this suggestion very or somewhat acceptable.

In passing, I think it is worth highlighting the willingness of hospital administrators to support many policies—not all of them, but many policies—designed to reduce hospitalization, in spite of the fact that these would presumably reduce their own hospitals' revenues.

Policies which set fixed fees and charges by hospitals and doctors are generally popular with the public, but get a mixed reception from the other groups whom we surveyed.

A system in which fixed fees are paid to doctors and to hospitals for treating patients with particular types of diagnoses are acceptable to 75 percent of the public and to majorities of all groups except physician leaders, two-thirds of whom regard DRG's, if applied to physicians as well as to hospitals, as unacceptable.

Now, for a variety of reasons, DRG's do not seem to be equated in the minds of most of the people whom we interviewed as being government price controls. This is clear from the answer to the next question which shows that a majority only of the public supports the concept of government price controls for health care services. The use of these dreaded words produces a high level of unacceptability, not only among physicians and hospital administrators, but among insurance executives and corporate benefits officers as well.

Now, perhaps, the most difficult and the most emotional of all the cost-containment policies which we tested is that of limiting the use of expensive treatment and technology for patients who have virtually no hope of recovery. This is one of the few suggestions where we found a big difference between perceived effectiveness and acceptability. Majorities of all six groups thought the policy would be effective in reducing costs, but opinion was much more equally divided on whether or not the policy would be acceptable. Indeed, large majorities of insurance executives and corporate benefits officers regarded such policy as unacceptable. Hospital administrators and the public are more or less equally split. The only group with a majority for whom this is acceptable is the physician leaders who, by 59 to 38 percent, are willing to go along with it.

Now, I think it is clear from the data in our survey, which I have shown you, that the American people are very concerned that nobody should be denied medical care. Before just very quickly summing up the important points in the survey, I think I would like to stress that any new policies which would significantly reduce the access of the poor, the underprivileged, and the elderly, would be fiercely resisted by many Americans who are not themselves any of these things.

In conclusion, I would like to just highlight seven key findings.

First, we found a general and widespread feeling that something is badly wrong with the Nation's health care system. Three out of every four Americans believe that either fundamental changes are needed or that we need to completely rebuild the system.

Second, the main reason people feel this way is that the perception that costs are much too high and are out of control. Some people focus their criticism on the overall cost of hospitalization and doctor fees, others on the out-of-pocket cost, which they believe the elderly and underprivileged cannot afford.

Third, we do not have a free competitive market for health care services. Consumers do not choose their medical care providers on the basis of price. Indeed, there is virtually no price competition we could find between providers to keep prices or costs down.

Fourth, that in their desire to make changes and control health care costs, the American people are surprisingly willing to accept a broad range of policies which involve some sacrifices in terms of additional cost sharing and reduced freedom of choice. These policies, I should stress, are not their most favored ideals, but what they are willing to accept and go along with. Policies which most people are willing to accept include increased deductibles and payments, preferred provider organizations—PPO's—policies with incentives to encourage the treatment of patients outside hospitals and penalties for nonessential hospitalization, prospective payments based on DRG's, and greater use of nurse-practitioners and physician assistants.

To this committee I should add, that on most questions, the views of medicare recipients differ very little from those of the adult population as a whole.

Fifth, most of the policies that we presented are acceptable not only to the public, but also to most hospital administrators, most corporate employers, health insurance executives, and trade union leaders.

Sixth, physicians, insofar as their elected leaders represent them—we did not do a national cross section of physicians, only physician leaders—are most likely to provide the greatest resistance of change. They are the only group we surveyed who are satisfied with the status quo, and the only group who believed that we already have a price competitive system. They regard many, but not all, of the proposed cost-containment policies unacceptable. To be sure, they have no problem with decreased deductibles and copayments, and they will support most policies designed to encourage treatment outside hospital settings. But they are overwhelmingly hostile to all alternatives to the traditional fee for treatment, and to both prior approval and second opinions before nonemergency surgery and hospitalization.

I should add that several medical leaders have suggested that our findings are not representative of most working doctors who, they say, are progressive, not satisfied with the status quo, and willing to accept many changes. If that is true, that is obviously very good news.

The question I suppose that the survey leaves you with, Senators, is whether American leadership of government and in the private sector can take advantage of the opportunity which our survey shows to be there, to bring health care costs under control.

Thank you very much.

Chairman Heinz. Thank you very much, Mr. Taylor.

I think there is a small oversight in your testimony that I should like to remedy. What you left out was a very good Winston Churchill quote, which is from your testimony. He said that the American people can always be relied upon to do the right thing after they have exhausted all other possibilities. And my good friends on this committee know, having served as a member of the Social Security Commission, that that is exactly how we got to this strange hodgepodge of measures. I can remember every member of this committee voting against the taxation—along with every Member of the Senate I might add—against the taxation of social security benefits. That is one of the worst plagues to visit mankind in perhaps 3,000 years. Yet, we all voted ultimately to include the taxation, at least above certain income levels in that package.

[The prepared statement of Mr. Taylor follows:]

PREPARED STATEMENT OF HUMPHREY TAYLOR

I'm honored to be here, and grateful for this opportunity to tell you, very briefly, about a very important survey which we have just completed for the Equitable Life Assurance Co. of America. The survey deals specifically with the issue of health care cost containment in both the public and private sectors. My colleagues and I are particularly grateful that the Equitable, having funded the project, did everything possible to insure that this would be a fair, balanced, and comprehensive study. While they encourage us to talk to a wide range of experts in the private sector, in government, and in the medical world, they made no attempt to point us in any particular direction. Our brief was only to do the best possible job, and to do it to the best of our ability, without fear or favor to any of the many parties in the debate about health care costs and cost containment.

This survey was designed not just to be yet another analysis of the problem of health care costs, but to be part of the solution, as a tool for people in government and in the private sector who are having to make some very tough decisions.

The survey has substantial sections covering such things as the general attitudes of the American people toward their health care system, their perceptions of reasons for the great increase in health care spending and health care costs, their reactions to a series of very specific cost-containment proposals, as well as their opinions on such things as cost shifting and health care coverage for the unemployed, and the experiences and policies of corporations and labor unions with different kinds of health care programs.

The study is based not just on a survey of a cross-section of American adults. It also includes separate surveys of physician leaders who head State, local, and specialty societies throughout the country, hospital administrators, health insurance company executives, corporate benefits officers, and labor union officials.

One word of caution about the physician sample is necessary. We did not interview a representative cross-section of physicians. The 100 physician interviews were with the elected leaders of State and local specialty societies throughout the country and who are, of course, the principal representatives of and spokespersons for their members.

With that let's look at a few of the key findings in this survey—and let me stress that I only have time to show you a very small selection of these findings.

A good place to start is with overall views of the American health care system. As you can see, the American public is far from satisfied with the status quo. Indeed, only 21 percent of all adult Americans believe that on the whole, the health care system works pretty well, and that only minor changes are necessary. Fully 50 percent believe that, while there are some good things in the system, fundamental changes are needed to make it better, while a quarter think that the system has so much wrong with it that we need to completely rebuild it. I should add that majorities of hospital administrators, insurance executives, corporate benefits officers, and union leaders endorsed the second of these three responses—that fundamental changes are needed. A majority of only one group endorsed the status quo; 68 percent of physician leaders believe that only minor changes are necessary to improve our health care system.

Next, we asked people to tell us, in their own words, what would be their first priority if they could make one change in our health care system. As you can see cost-related and access-related changes headed the list of public responses. Furthermore, many of the responses relating to access dealt with cost barriers which prevent elderly Americans and those with low incomes from obtaining access to care. There is a widespread feeling that many older Americans do not have adequate access to health care services, a finding which (as you will see) is not borne out by the experiences of the elderly themselves.

From all these and much other data in this and other surveys, it is clear that public concern about the cost of health care is very great, even if in the great majority of cases they are paying the full cost of their own health care directly.

Before moving on to look at the cost issue in more detail, I would like to share with you three other findings from the first section of the report.

One very important finding is that only 16 percent of all American adults say that they have ever, at any point in their life, selected a doctor because his or her fees were lower than those of another doctor.

Another set of questions deal with the issue of access to, and barriers to obtaining, needed medical care. On the one hand it is very reassuring that the overwhelming majority, 86 percent of all adult Americans, report that they and their families had been able to obtain all the medical services which they needed in the previous 12 months. On the other hand, it is, I think, a matter of very grave concern that 14 percent (which may look like a small number but which represents more than 11 million American families) reported that on at least one occasion, and possibly more, they failed to obtain needed medical help.

You should also note that medicare—whatever its shortcomings and costs—is rather successful in doing what it was designed to do, that is, provide the elderly and the disabled with access to care. Only 8 percent of medicare beneficiaries reported that they (or their families) failed to obtain needed care.

On the other hand, families without any insurance are much more likely to have problems. Fully, a 32 percent of them failed to obtain care they needed.

While many different reasons were given to explain why they did not get needed medical help, the answers given the most frequently referred either to the high cost of care or to inadequate insurance coverage.

The next section of the report—which time does not permit me to show—provides a detailed analysis of people's perceptions of the reason for health care cost inflation and increased spending.

What it showed was a general recognition that the causes are not simple, but many and varied.

In one set of questions we asked each of the people we interviewed to tell us whether they agreed or disagreed with various statements. The replies both from the public and from the professional samples underline the absence of cost-containment mechanisms in the system as we know it. The overwhelming majority of the public—and each of the leadership groups—believe that if most patients don't have to pay for hospital care they will want the best care available, no matter how expensive it is. That presumably is human nature. There is also a very strong belief in all the groups sampled that cost sharing could reduce demand, that people would use fewer health care services if they personally had to pay a greater share of the costs.

What this amounts to, of course, is a recognition that what we have at the moment in no way resembles a free competitive marketplace. Or as most people put it, that there is no real competition among health care providers to keep prices down.

One of the reasons for this—people believe, not unreasonably—is that if doctors and hospitals know that insurance and not the patient is paying, they will provide care without regard to costs.

In the interest of not overwhelming you with numbers I have only made a few passing references to the replies of the various professional groups. However, I think it is noteworthy that the overwhelming majority (80 percent or more) of insurance executives, corporate benefits officers, and union leaders agree with the statement that there is no real competition among health care providers, that a majority of hospital administrators (55 to 42 percent) also share this view, but that by 73 to 27 percent, the physician leaders disagree. Indeed, as you will see from the report the differences between the replies of the physician leaders and all of the other groups surveyed in response to many of the questions is one of the most striking findings of this study. Unlike any other group, physician leaders are much more satisfied with the status quo and are much more likely to believe that we have a price sensitive competitive marketplace for health care services, and as a result, are much less willing to go along with proposals for changes in the system.

We now come to what is, I think, the heart of this survey. After an extensive review of the literature, of the various bills that are working their way through the Congress, and of the many proposals which have been made in the private sector for health care cost containment, we boiled these down to 24 specific policies, some of which are already being tried and some of which are as yet only on the drawing board. We asked the people we interviewed two questions about each of these policies; how effective they thought it would be in controlling costs or discouraging the use of nonessential services, and how acceptable it would be to them personally, or (in the case of the professional groups) as professionals in this field.

One finding which is true of the great majority of all these specific proposals is that there is a high correlation between the acceptability and the perceived effectiveness of different policies. When a policy is perceived to be effective, it is likely to be acceptable. And the more effective it is believed to be, the more likely it is to be acceptable.

I would like to stress that we did not ask people whether they favored or opposed these policies, but whether the policies would be very acceptable, somewhat acceptable, not very acceptable, or not at all acceptable. Given that many of the policies have somewhat disagreeable consequences for the public, or for providers, or for third-party payers, it seemed to us that the essential question was not what they would like, but what they would accept and go along with.

I think that you will find the answers to these questions both surprising and encouraging.

I will look first at proposed changes in health care coverage which are designed to reduce nonessential utilization by increasing the out-of-pocket costs of health care to patients. The fact that so many Americans are prepared to go along with policies of this type is, I think not only a surprise, but an indication of the widespread concern of the American people, who clearly recognize that some fairly disagreeable remedies are necessary if health care costs are to be brought under control.

As you can see, 65 percent of the American public told us that it would be very or somewhat acceptable to require employees to pay a part of their own health insurance premiums. Only 32 percent said it would not be very or not at all acceptable.

Fifty-eight percent told us that it would be acceptable to increase the deductibles that they pay, and 52 percent are willing to accept increased copayments, although, as you can see, almost half (46 percent) oppose this.

One policy which most people regard as unacceptable is the proposal of the administration to tax the top end of the more expensive health insurance premiums. One reason why this proposal is unacceptable to a 56-percent majority of the public is their view that it would not be effective, presumably because under this proposal there is nothing that the individual employee can do—in the way of reduced utilization—to avoid paying the tax.

Changes in health insurance plans that would provide a lower cost option to patients, usually with some built-in constraints, such as less freedom of choice of health care providers and procedures, are widely believed to be effective in containing health care costs and are generally, though not universally, acceptable.

There is overwhelming public acceptance of the concept of second opinions for nonemergency surgery. Indeed only 10 percent regard that as unacceptable.

Fully 63 percent would be willing to accept a system that would encourage use of nurse-practitioners, midwives, and physicians' assistants. However, as you can see, the overwhelming majority of physician leaders (75 percent) regard this proposal as unacceptable. Hospital administrators are, on balance, supportive by 59 to 40 percent.

Almost 7 out of every 10 Americans would be willing to accept a system which requires patients to select physicians from a list of doctors who would provide basic medical care for a predetermined fee, and also assume the responsibility for authorizing of services of specialists, labs, and hospitals. This, however, is another proposal to which a majority (albeit a more modest majority) of physician leaders are opposed.

The majority of the public and of hospital administrators regard a prepaid plan with a monthly fee, in turn for which patients receive all physicals, doctors' visits, and hospitalization as acceptable. This, of course, is the HMO concept. Here again, a majority of 61 to 37 percent of physician leaders think this proposal unacceptable. Health insurance which would include only hospitals and doctors who charge lower prices and which would exclude those which charge higher prices is also acceptable to a majority of the public. However, this proposal is unacceptable to more than two out of every three physician leaders and to over half of all hospital administrators.

A less stringent variant of this scheme in which patients can go outside the selected list of physicians and hospitals, but where they would pay a higher cost for doing so, is acceptable not only to a majority of the public, but also to most hospital administrators. This is the typical planned provider organization, or PPO. In light of what we have seen already, it is no surprise that a majority of physician leaders oppose this concept also.

One proposal which is universally acceptable to large majorities of all the groups that we surveyed is a modification to health insurance plans to offer incentives to people who practice health and safety procedures—such as nonsmokers, seatbelt users or those who are not overweight. Only 18 percent of the public is opposed to this.

In light of the fact that most people recognize the necessity of eliminating unnecessary hospitalization, it is not surprising that a majority of the public support most suggestions designed to achieve this. For example, only 16 percent do not think it acceptable to have a system that encourages people to have tests and minor surgery done in clinics and doctors' offices rather than in hospitals. It is noteworthy that this proposal is acceptable, not only to the public, but also to the overwhelming majority of both physicians and hospital administrators.

Another somewhat similar proposal is to modify insurance plans to encourage the care and treatment of the chronically ill at home instead of in hospitals and nursing homes—a policy which is currently the subject of considerable scrutiny in the Congress. Large majorities of all the groups whom we interviewed find this suggestion very or somewhat acceptable.

In passing, it is worth highlighting the willingness of hospital administrators to support policies designed to reduce hospitalization, in spite of the fact that these would reduce their hospitals' revenues.

Policies which set fixed fees and charges by hospitals and doctors are generally popular with the public, but get a mixed reception from the other groups we surveyed. A system in which fixed fees are paid to doctors and hospitals for treating patients with particular types of diagnoses—commonly known as DRG's—are acceptable to 75 percent of the public and to majorities of all groups except physician leaders, two-thirds of whom regard DRG's, if applied to physicians as well as to hospitals—as unacceptable.

For a variety of reasons DRG's are not normally equated in the minds of most of the people whom we interviewed as being government price controls. This is clear from the answers to the next question which shows that a majority only of the public supports the concept of government price controls for health care services. The use of these dreaded words produces a high level of unacceptability, not only among physicians and hospital administrators, but among insurance executives and corporate benefits officers as well.

Perhaps the most difficult and emotional of all the cost-containment policies which we tested is that of limiting the use of expensive medical technology for patients who have virtually no hope of recovering. This is one of the few suggestions for which there is a big difference between perceived effectiveness and acceptability. The majorities of all six samples thought that this policy would be effective in reducing costs. Opinion was much more equally divided on whether or not such a policy would be acceptable. Indeed, large majorities of insurance executives and corporate benefits officers regarded such a policy as unacceptable. Hospital administrators and the public are almost equally split. The only group with a majority for whom this is acceptable is the physician leaders, who by 59 to 38 percent, are willing to go along with it. If I may venture an interpretation of these numbers, I think it may be that physicians are the only group interviewed who are regularly exposed to dying patients and who have witnessed not only the high costs of heroic medicine but also the extreme pain and suffering which some dying patients and their families have experienced as a result. However, I should add that this may be a personal view, not uninfluenced by the fact that both my parents were physicians, and both of them were determined that no one should try to prolong their lives when they knew the end was near.

So far we have looked at some of the proposals covered by our survey in isolation. In practice, changes in health insurance plans involving increased cost sharing are often linked to additional benefits designed to make the changes more palatable. Our survey therefore included a number of trade-off proposals where some kind of reduction in benefits or constraints was linked to an additional benefit. In each of these cases the majority of the public regarded the proposal as fair and reasonable—although, of course, the exact numbers vary from proposal to proposal.

By 67 to 28 percent, most people think it would be reasonable to provide better coverage for tests conducted without hospitalization than for tests involving overnight hospitalization.

By 65 to 30 percent, most people think it fair and reasonable to require higher deductibles and copayments if dental and vision benefits are added.

By 61 to 34 percent, most people think it fair and reasonable to require higher deductibles and copayments for the initial cost of health care, if it is linked to better coverage for the cost of longer term treatment.

By a more modest 52 to 44 percent, most people think it fair and reasonable to require a patient to pay a larger share of the cost of care obtained at hospital emergency rooms, if the plan also provides better coverage for treatment at doctors' offices.

And by 51 to 44 percent, a slender majority think it fair and reasonable to require patients to pay a larger share of the cost of overnight hospital stays, if insurance provides better coverage for surgery that does not involve hospitalization.

The crucial message which comes out of this section of our survey is that the public is ready to accept a remarkably broad range of cost-containment proposals. Indeed, the conventional wisdom that most people will resist major changes in our health care and health insurance system is, I think, conclusively disproved.

However, it is clear from the data I showed you earlier, as well as from many other surveys, that the American people are very concerned that nobody should be denied medical care. Any new policies which would significantly reduce the access of the poor, the underprivileged, and the elderly would be fiercely resisted by many Americans who are not themselves any of these things.

From the wealth of data in our survey, I would highlight seven key findings:

First, there is the general and widespread feeling that something is badly wrong with the Nation's health care system. Three out of every four Americans believe either that fundamental changes are needed or that we need to completely rebuild the whole system.

Second, the main reason people feel this way is their perception that costs are much too high and are out of control. Some people focus their criticism on the overall costs of hospitalization and doctors' fees, others on the out-of-pocket costs which they believe the elderly and the underprivileged cannot afford.

Third, we do not have a free competitive marketplace for health care services; consumers do not choose their health care providers on the basis of price. There is virtually no price competition between providers to keep prices or costs down.

Fourth, that in their desire to make changes and control health care costs, the American people are surprisingly willing to accept a broad range of policies which involve some sacrifices—in terms of additional cost sharing or reduced freedom of choice. These policies are not their most favored ideals, but what they're willing to accept.

Policies which most people (of course, not everybody) are willing to go along with include increased deductibles and copayments, prepaid plans, such as HMO's, preferred provider organizations (PPO's), policies with incentives to encourage treatment outside of hospitals and penalties for nonessential hospitalization, prospective payments based on diagnosis related categories (DRG's) and greater use of nurse-practitioners and physicians' assistants. To this committee I should add, that on most questions, the replies of medicare recipients generally differ very little from those of the adult population as a whole.

Fifth, most of these policies are acceptable not only to the public, but also to most hospital administrators, corporate employers, health insurance executives, and trade union leaders.

Sixth, physicians—insofar as their elected leaders represent them—are likely to provide the greatest resistance to change. Indeed, it is not an exaggeration to say that they are out of step with the Nation. They are the only group we surveyed who are satisfied with the status quo, and the only group who believe that we already have a price competitive system. They regard many, but not all, of the proposed cost-containment policies as unacceptable. They have no problem with increased deductibles and copayments, and they will support most policies designed to encourage treatments in nonhospital settings. But they are overwhelmingly hostile to all alternatives to the traditional fee-for-service system, such as HMO's, preferred provider organizations, capitation fees, prospective payments (at least if these are applied to doctors, as well as to hospitals), and to both prior approval and second opinions before nonemergency surgery and hospitalization. I should add that several medical leaders have suggested that our findings are not representative of most working doctors who (they say) are progressive, not satisfied with the status quo, and willing to accept many changes. If that is true, it is obviously very good news.

Finally, the survey provides a warning. The overwhelming majority of the public (71 percent) who favor government price controls of doctors' and hospitals' fees are waiting in the wings to see if employers, insurers, and providers—with whatever help they may need from the government—can get health care costs under control by less Draconian measures. Historically, the American people turn to government only as a last resort when every other approach appears to have failed. Winston Churchill once said, that the American people can always be relied upon to do the right thing—after they have exhausted all the other possibilities. Unless the American people can be convinced that the inflation of health care costs has been dramatically reduced, they may soon believe that they have exhausted the other possibilities and that the only remaining alternative is tough government regulation.

The question is: Will American leadership take advantage of the opportunity, which our survey shows to be there, to bring health care costs under control before that happens?

Chairman HEINZ. I want to recognize, first, Senator Chiles and Senator Percy, and ask if they have any comments or opening statements they would want to make.

Senator Chiles, you snuck in the door ahead of Senator Percy, so you have precedence on that.

STATEMENT BY SENATOR LAWTON CHILES

Senator CHILES. Mr. Chairman, I first want to congratulate you for holding these hearings. There is no more important subject for our elderly, and really no more important subject for the country, than what do we do about hospital and health care costs that are rising at a rate of over 16 percent a year. Our inflation is just under 4 percent a year, so this is a fourfold increase over inflation.

We in the Congress have long been used to weapon systems outdistancing almost every other rate of inflation, but now we see that they are pikers in regard to health care costs. And we only have to look at what we see happening to the medicare funds, and medicaid by even 1986, to know that we are now viewing the next catastrophe after social security. How to get some kind of handle on that is tremendously important.

I think that the Harris survey has got to provide some valuable insight to the committee. And I think that it has long been this committee that has tried to be the harbinger of change. And while we have never had legislative authority, it has many times been this committee that has provided the impetus for some change. So obviously, that is something that has to be done in this area.

I have a prepared statement that I would like to submit for the record. I congratulate you on these hearings, and I know that they are going to be very, very important.

Chairman **Heinz**. Thank you very much. We are delighted to have you. You have served with such great distinction as the chairman and ranking member of this committee for many years. I will not introduce you as chairman of the Budget Committee at this point. We will keep you as ranking member though for as long as you care to serve.

[The prepared statement of Senator Chiles follows:]

Prepared Statement of Senator Lawton Chiles

I congratulate the chairman for having these hearings today.

As a past chairman of this committee—and now as the ranking minority member of the Budget Committee—I can say, without batting an eyelash, that controlling health care costs is the biggest social and economic policy problem we face in this country today.

Health care prices cannot continue to rise as they have over the last several years. No one can afford it. Medicare is going broke—and we are simply going to lose the program unless something is done about costs. No one—of any age—will be able to afford the kind of health care we are used to today.

It is interesting to see how far we have come in our realization of this fact. It seems that everyone is worried about health care costs. I note with interest that one of our witnesses this morning told us about the results of a recent Harris poll on health care costs. I want to examine the findings in detail—but from what I have heard, the poll basically showed that a vast majority of Americans are worried enough about health care costs to accept some major changes in the health care system. That includes the elderly, other health care consumers, the business community, unions, and hospital administrators. Maybe even the doctors—who like things the way they are—are ready to go along.

Look at what is happening with medicare now. Over the past few years the elderly have been asked to tighten their belts, taking higher and higher out-of-pocket costs. Hospitals have had to tighten up too. This year we asked the doctors to contribute their fair share. We asked them to accept a COLA delay—just like everyone else—by putting a temporary freeze on their fee increases under medicare.

The House is going to vote this week on whether or not to institute a freeze, along with a provision for mandatory assignment. I've noted that the doctors are now fighting that plan. We should watch that carefully.

But even if we could get major changes in medicare—that would not be enough to take care of the problem of rising health care costs. We will ultimately have to have systemwide reforms much larger than anything that can be done in medicare itself. The business community, the insurance industry, and State governments all certainly have as strong a motivation to act as we do with medicare. They are all victims of high health care costs too.

One way or another, we are going to have to learn how to work together and complement each other's efforts, or we won't get anywhere. This hearing should help us get started.

Chairman **Heinz**. I would like to turn now to Senator Percy, who is the senior member of this committee, and looks none the worse for the wear.

STATEMENT BY SENATOR CHARLES H. PERCY

Senator **Percy**. Well, I get more interested in it every year, Mr. Chairman.

I also have observed, in going into retirement homes in this past year, that there has been a total reversal of questions now put to me by elderly people there. Before, it was totally dominated by, "Is the social security system going bankrupt?" That was a cause of tremendous worry.

The study I did 10 years ago that led to my book, "Growing Old in the Country of the Young," revealed that certainly the greatest worry on the part of all people is lack of income in their aging years. I would say right now we have covered that problem in social security. I do not get any questions on it. They seem totally satisfied, thanks to you and your Commission, that we in the Congress together, have solved that problem.

Now, the concerns about social security have been replaced by concerns about medicare. I commend you for this hearing which follows up on the April hearing on "The Future of Medicare." I do not think we should wait for the Commission to report, but instead better prepare the Congress, particularly ourselves in the Senate, to deal with this problem that 27 million Americans are deeply concerned about; medicare will possibly face a deficit by 1987, just 4 years away.

The enactment of a prospective payment system for hospitals that provide services for medicare beneficiaries as part of the social security bill signed into law earlier this year is, I think, an important first step taken in addressing this problem.

There are several different ways, or a combination of ways, that we can approach the problem. States and localities and the private sector have, in recent years, developed a number of programs for controlling health care costs, and that is why I think it is important this morning we hear from them.

I ask that my formal statement be incorporated into the record at the appropriate point. And, I certainly welcome all of our witnesses and appreciate the consideration they have given to their testimony.

Senator HEINZ. Senator Percy, thank you very much.

[The prepared statement of Senator Percy follows:]

PREPARED STATEMENT OF SENATOR CHARLES H. PERCY

Mr. Chairman, I commend you for this hearing following up on the committee's April hearing on "The Future of Medicare."

At that time, I stated how imperative it is that we act—just as we did with social security—to preserve the medicare program, which provides assistance to 27 million elderly Americans and 3 million disabled persons. Unless we take some action, the hospital insurance trust fund is expected to face a deficit in 1987—less than 4 years away. The enaction of a prospective payment system for hospitals that provide services to medicare beneficiaries as part of the social security bill signed into law earlier this year was an important first step toward addressing this problem.

Obviously, though, much more needs to be done to bring outlays in line with revenues. Three major policy options for medicare are often discussed. We can increase revenues, either by raising the medicare portion of the payroll tax or through special taxes earmarked for medicare; we can increase beneficiary cost sharing; or we can further limit provider reimbursement. Or, we can use a combination of all three.

While such measures would deal with the immediate solvency crisis, they do not get at the root of the problem. Medicare outlays have been growing at an annual rate of 17.7 percent since 1970, largely because of rapidly rising medical costs. To control medicare costs over the long term, it may well be necessary to take steps outside of the program to slow the rate of increase in the cost of health care.

States, localities, and the private sector have, in recent years, developed a number of programs for controlling health care costs. This morning, I look forward to examining what has been learned from these various systems, particularly with regard to their effectiveness, their applicability to other conditions, and the need to hold down costs without compromising either the availability of services or quality of care.

Chairman HEINZ. Mr. Taylor, I think we all have a number of questions for you. I will try and make mine brief.

Your survey indicated that the public, perhaps not physicians, but the public is ready to accept a broad range of cost-containment approaches or proposals, including those under certain circumstances, of increased out-of-pocket costs and minimum freedom of choice. And you also indicated which proposals are most acceptable to the public in that regard.

Based on the survey data, what attitude does the public have to medicare cost containment? And what are the greatest opportunities of public consensus if it is necessary to reduce medicare costs? You have talked about health care generally for most of your presentation. I would like you to focus to the extent you can on medicare.

Mr. TAYLOR. Thank you.

There are many surveys, not just this one, which indicate that of all of the Federal Government financed programs, health care enjoys one of the strongest levels of support, including support for funding of medicare. And surveys which ask people where spending should be increased or where should spending be cut, always show medicare right up at the top of the list with social security enjoying a great deal of public support.

Second, as this and other surveys also show, cuts in medicare benefits which substantially reduced access among the elderly or disabled would run into very tough opposition indeed.

Chairman HEINZ. And that is not just for medicare beneficiaries——

Mr. TAYLOR. No; that is true of the population across the board. Partly because people will get old themselves, partly because people have older relatives, and partly from a genuine concern for older people.

Where, therefore, does the solution come? And it seems to me that the solution to the medicare funding problem, which you gentlemen will eventually reach, will be based not only on cost containment for the whole health care system, on which it must obviously be based, but also on a compromise between increased funding, specific cost-control mechanisms for medicare itself, and some reduction in benefits. And I think that ultimately a policy which combines all of those three elements will be acceptable as public awareness of the crisis grows.

Chairman HEINZ. What specifically is the public attitude with respect to medicare on tougher cost constraints on providers such as DRG-type control?

Mr. TAYLOR. Overwhelming supportive. And it is interesting that DRG's and other alternative systems are supported by everyone of the groups whom we interviewed except, as I said earlier, the physician leaders.

Chairman HEINZ. Now, is the support for that kind of cost control—I do not know if you surveyed this—equally enthusiastic for cost controls on doctors' fees as on hospital charges?

Mr. TAYLOR. There is slightly more concern about hospital charges, in fact, significantly more concern about hospital fees than about doctors' fees. And I would, therefore hypothesize—we do not specifically have data on this—that if they had to choose, the first priority would be for DRG's on hospital charges.

Chairman HEINZ. What would be the impact with respect to medicare beneficiaries of additional cost sharing?

Mr. TAYLOR. Well, clearly for many of them, additional cost sharing will be a real burden. Having said that, we did find that medicare beneficiaries answered the questions almost identically to the population as a whole. And I think they are willing to make some additional sacrifices as part of an overall policy to deal with the problem.

Chairman HEINZ. You said earlier, if I understood you, that additional cost sharing, which would reduce the access of the medicare beneficiaries to health services, would not be acceptable, not just to the medicare beneficiaries, but to the public at large. Is that correct?

Mr. TAYLOR. That is correct. There is a very, very strong feeling that nobody should be denied health care when they really need it. In marginal cases, yes, but not when they really need it for serious complaints and they cannot afford it.

Chairman HEINZ. Finally, you pointed out that medicare is one of the most popular programs that the Federal Government has. Indeed, I imagine the only other program that enjoys similar approvals is the social security system itself.

What is the public attitude toward paying higher medicare costs in one of two ways, either through higher taxes on them, the people who pay payroll taxes, or through cost shifting, should we use a method of cost control, such as DRG's, which would simply clamp down on medicare and squeeze costs onto the other parts of the health care system?

Mr. TAYLOR. I should perhaps say, of course, this was not a survey only about medicare, but about cost containment generally. And, therefore, we did not include questions about higher taxes for medicare benefits. And probably the wisest thing is not to guess what those answers might be.

As far as cost shifting is concerned, we did ask the question. And insofar as there really is cost shifting, the public does not think that is acceptable.

Chairman HEINZ. Could you enlarge on why medicare beneficiaries will not approve of price shifting?

Mr. TAYLOR. They regard it as inequitable, that in order to provide health care services for themselves that the cost of that should be shifted onto the private sector or to other people who are not medicare beneficiaries.

Chairman HEINZ. Thank you very much.

Senator Glenn.

Senator GLENN. Thank you very much, Mr. Chairman. I have a couple of questions.

Did your study break down the differences in attitudes toward HMO's—general population attitudes toward HMO's, as well as just the elderly attitudes toward HMO's? Medicare outlays rank about 30 percent for people in their last year of life; there is a tremendous increase in health care in that last year. It runs the whole medicare costs very much uphill in that last time period, and that is completely understandable. It is probably tied into the fact that hospital costs are over 40 percent of total health care costs, and they are the fastest growing component of health care costs.

Is there a difference in attitudes toward HMO's? I have thought for a long time that the HMO concept was one of the best ways we could go. Are there different attitudes toward HMO's in the different age groups—did you break that down?

Mr. TAYLOR. In every age group we found overall willingness by substantial majorities to accept the HMO concept. I should perhaps add, that other surveys have shown that patients that have HMO's of all age groups are, nationwide, overwhelmingly satisfied with the quality of the service they receive from these HMO's.

Senator GLENN. Thank you, Mr. Chairman.

Chairman HEINZ. Thank you, Senator Glenn.

Senator Percy.

Senator PERCY. Just one question.

The findings of your survey are enlightening. Did you make the distinction between the general public and the elderly in their attitudes toward changes in the health care system, particularly with regard to out-of-pocket costs?

Mr. TAYLOR. Yes; we looked at the elderly and medicare beneficiaries specifically, in relation to each and every one of those proposals with regard to cost sharing. The striking finding was that they were not significantly different from the public as a whole.

Chairman HEINZ. I want to recognize Senator Grassley of Iowa. Senator Grassley, we welcome you. Is there a statement you want to make or any questions?

Senator GRASSLEY. I am here too late for questions of this witness. I have a statement I would like inserted into the record.

Chairman HEINZ. Without objection, so ordered.

[The statement of Senator Grassley follows:]

STATEMENT OF SENATOR CHARLES E. GRASSLEY

Mr. Chairman, I thank you, and the committee staff, for calling and preparing this hearing.

The very title, "Controlling Health Care Costs" is provocative, especially as the witness list indicates, it is a probe of initiatives carried out in search of this goal by all levels of government, as well as the private sector.

In early November, this committee intends to hold a similar hearing in Sioux City, Iowa, which I will chair. The title, "Crisis in Medicare: Options for Reform." It will continue the policy of this committee in bringing out what must be done to hold down costs, while delivering effective hospital care to all Americans, now and in the future.

Mr. Chairman, it is this rational, nondemogogic, and early-on approach to a potentially explosive subject that will allow the Congress to work out what needs to be done. Thank you again for taking this responsible lead, and I look forward to hearing and reading this morning's testimony.

Chairman HEINZ. Mr. Taylor, I have one other question that occurred to me as you were answering questions from Senators Glenn and Percy. It has to do with the perception of access to health care.

You mentioned that there is a widespread feeling that many older Americans do not have adequate access to health care, yet the elderly do not feel that way themselves. Can you explain that to us?

Mr. TAYLOR. Yes; I can certainly give you more data on it which may partly explain it.

We asked a question of everybody we interviewed as to whether they, or anybody in their families, have had any difficulty, or have failed to obtain any needed medical care in the last 12 months. The figure for the entire adult population was 14 percent. Among medicare beneficiaries it was only 8 percent. They do not have more trouble. They tend to have less trouble, it would seem, in getting access to care than the population as a whole.

Chairman HEINZ. Can I ask a question? Among that 14 percent, did you have a cross tab between people who were employed and unemployed?

Mr. TAYLOR. Yes; and the figure rose sharply among the unemployed. The highest number we found, I think, was 32 percent among those who had no health insurance coverage, either from the public or the private sector.

Chairman HEINZ. What was it among those who had coverage?

Mr. TAYLOR. From memory—who had coverage?

Chairman HEINZ. Who had coverage, nonelderly.

Mr. TAYLOR. Who are employed?

Chairman HEINZ. Or who had coverage by virtue of——

Mr. TAYLOR. It varied a bit. Among the employed group, I think it was about 12 percent. Among the medicaid beneficiaries, 8 percent.

Chairman HEINZ. So, even among the unemployed people, it was higher than among medicare beneficiaries?

Mr. TAYLOR. Yes.

Chairman HEINZ. I see. Thank you.

Just to pin this down, to what do you attribute, as I understand your statement, that the public, as a whole, believes that medicare beneficiaries, older Americans, as you put it in your statement, do not have adequate access? Are they simply projecting their own experience, or do they know something that the elderly do not, or we do not know?

Mr. TAYLOR. I think it is a combination of historical circumstances. It is, in many cases, reflecting situations before the medicare program was as effective as it is. It may well be said by anecdotal evidence which is not typical of the mass of older Americans.

Chairman HEINZ. I want to apologize to my colleagues for persisting in this, but I find this finding an interesting one. Is there any possibility that the other respondents, the nonmedicare respondents, nonsenior citizen respondents, were reflecting views not specifically related to acute care, but were reflecting views with respect to long-term care, that, in fact, medicare does not pay for long-term care?

Mr. TAYLOR. I think that is very probable.

Chairman HEINZ. Thank you.

Senator Glenn.

Senator GLENN. I just have one other one.

Did you run other surveys in the past, where you had statistics on whether the public was willing to accept wage and price limitations specifically imposed by the Government, because of other cost increases, too—whether we are talking about autos, houses, wages, or whatever? It bothers me a little bit that even though most physicians are reasonably well paid, that we are almost assuming that we would embark on some sort of imposed Government regulations on this specific industry. There will not be a cost rise period. This is a rather onerous approach to take if we find this expanding into other areas, too.

Have you run any surveys that showed if people had the same idea on housing costs, the same idea on automobile costs, or the same idea on other costs, as far as imposing a Government edict on costs not going above a certain amount?

Mr. TAYLOR. Senator, you are right, I think, in suggesting that the public has tended historically to support the idea of Government price controls in many different areas, not just in relation to health care costs. Having said that, there is also survey data available from other surveys, which show that of all the costs in which people are concerned, health care in general, and hospital costs in particular, are very near the top of the list of people's worries and anxieties, and therefore, more likely to be a focus of public attention and demand for Government price controls.

Chairman HEINZ. Mr. Taylor, thank you very much indeed for—excuse me—Senator Chiles, do you have anything?

Senator CHILES. Gentlemen, I just have a couple of questions I want to ask.

I was interested in your statement in which you said that the physician leaders were the ones that were surveyed, and not the practitioners themselves. You made some reference in your statement that someone had said, that the general practitioners might be more progressive in their thoughts. Where did that come from?

Mr. TAYLOR. The chairman and elected leaders of a number of medical associations. For example, I think the chairman of the medical association in the State of Indiana, and probably 10 others, when they were exposed to the survey, and these data said, "You are not looking at us, we do not think like this. We recognize the need for change and we are willing to go along with a lot of these changes."

Senator CHILES. That seems to be an area that should have some additional probing or some additional study. Since this survey reflects sort of a broad consensus of the elderly public willing to take all these changes, I suspect if you would ask the leaders of many elderly groups, you would find the same kind of rigidity that you see in the physician groups against certain of the changes. And if we looked at the leaders, I think that we might find that many things, like cost sharing—I doubt if you are going to find any leaders of the elderly groups saying that there should be cost sharing. I doubt if you are going to find it in some of these other areas.

So it may be that there really should be some additional study of general physicians. Because the leaders tend to be resistive to change by virtue of just trying to keep their station.

Mr. TAYLOR. I would entirely agree with that statement and those conclusions. And I think it is quite possible that physicians would come out differently. Obviously, I would be delighted to do that research, if we could find somebody to fund it.

Senator CHILES. Thank you.

Chairman HEINZ. Senator Chiles, thank you very much.

Mr. Taylor, thank you. And you know, Winston Churchill had one other quote that I have always liked. He said that with respect to one particular group of people—I do not think he had physicians in mind—in wartime it is dangerous for leaders to live in the atmosphere of a Gallup poll, always feeling one's pulse and taking one's temperature. But we thank you very much for your assistance here today. Thank you.

Mr. TAYLOR. Thank you.

Chairman HEINZ. Our next panel consists of Carl J. Schramm, director, Center for Hospital Finance and Management, Johns Hopkins University, Baltimore, Md.; James Monroe, assistant professor of political science, Brown University, Providence, R.I.; John D. Crosier, executive director, Massachusetts Business Roundtable, Inc., Waltham, Mass.; and Frank S. Sloan, executive director, Health Policy Center, Vanderbilt University, Nashville, Tenn.

Gentlemen, would you please come forward and take your place at the witness table. We will proceed.

I would like to ask Dr. Schramm, who is the director of the Center for Hospital Finance and Management at Johns Hopkins University in Baltimore, to be our first witness. Dr. Schramm, we welcome you. Please proceed.

STATEMENT OF CARL J. SCHRAMM, PH. D., J.D., DIRECTOR, AND ASSOCIATE PROFESSOR, CENTER FOR HOSPITAL FINANCE AND MANAGEMENT, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD.

Dr. SCHRAMM. Thank you, Senator.

I have submitted a statement for the record,[1] but I would like to offer a quick synopsis.

Senator, I will constrain myself to a discussion of hospital cost inflation. I think that is a well-advised position, in the sense that hospitals account for well over half of all resources expended in the American health care system, and that in a hyperinflationary time, in general, hospital costs have outpaced all other health care costs. Indeed, as Senator Chiles has remarked, in recent years hospital costs have been running as high as 17 and 18 percent change per annum. Indeed, even at the present time, with the Consumer Price Index rising around 4½ percent, hospital increases this year will approach 9 percent. In other words, while the absolute rate of inflation appears to have dampened, the relative problem has, in effect, grown worse.

I would suggest that the particular difficulty in changing behavior in the hospital system as regards its burgeoning price problems relates to three particular issues. First is the problem of a reimbursement system that has been designed in the past. While many people will comment on the reimbursement system as introducing irrational, noneconomic, or inefficient behavior, I would like merely to point out that the reimbursement system as engendered by the Congress in 1965, with the passage of medicare and medicaid, caused profound changes in the hospital. As an institution, it created very strange institutional pressures; indeed, it changed the nature of the hospital as an entity doing business, and changed the nature of the hospital as a firm.

The predominant system of hospitals in the United States has been of a voluntary character operating for charitable purposes, as a nonprofit institution. The focus of its charitable enterprise had, prior to 1965, been the poor and those elderly without sufficient resources to pay for care. With the Federal Government coming on line as the payer or guarantor of payment for these two particular groups, the charitable nature of the hospital, in fact, was changed, and indeed in many respects, has no longer continued.

---

[1] See page 33.

This change in financing had marked and profound effects on the hospital as an institution. Progressively it behaved more and more as a for-profit firm operating in a cost-plus environment. Every single incidence of court examination of hospitals in the last 10 years has reinforced the nature of the hospital as just another entrepreneurial firm, and less a special, fragile institution in our society.

A second major change that caused a particular problem in changing behavior in hospitals has been the extraordinary growth of technology. Indeed, with the advent of technology growth, the practice of medicine and the nature of the product the hospital produces has changed accordingly. We have put in place a technology juggernaut that is almost impossible to stop, some aspects of which are useful for hospital purposes and some unuseful.

The third factor is the growth of the hospital sector itself. As we have all commented, we well know that there has been a change in this industry. We now spend over 10 percent of all energy in the society in the health sector, with well over 5 percent being spent in the hospital industry alone. With this extraordinary level of expenditures, we have created in the hospitals a dual function. They are as important in the employment they provide in communities as they are for the health care they provide for citizens in the given community.

The reason I have begun with these three particular problems, problems that cause difficulty in creating change, is that the hospital problem is basically an institutional problem, and I believe a problem requiring institutional remedies. I believe the remedies that have been attempted by the Federal Government and the private sector over the last 15 years have all but failed, as evidenced by the rate of change in hospital cost increases. In fact, I would suggest that the only remedy to date that has offered statistical changes in the rate of price change in hospitals has been regulation of the industry at the State level.

Today, 11 States have established mandatory all-payer ratesetting systems. Indeed, five of those States are relatively recent. The first six States established their legislative authority in the early part of the 1970's.

In my own State, Maryland, the general assembly passed the law that established a comprehensive, all-payer hospital rate regulation scheme in 1971. The theory of State intervention is quite clear. These institutions are nonequity institutions. They are in every sense, even by their own charters, public service or quasi-public institutions. They exist for the common good.

It is a mistake to be misled by theories and literature that suggest that the hospital is like any other for-profit firm; that it should be guaranteed the same freedom of mobility and movement, the same managerial discretion as General Motors, for example. Hospitals are chartered as nonprofit eleemosynary institutions and exist to be responsive to a community need. I believe that it is very appropriate for the law to regulate hospitals in the public utility mode, just as it is to regulate those companies that produce insurance, transportation, and energy.

The second point I want to make on the issue of State regulation is that it has worked. I have included as figure 2 in my prepared statement, a chart demonstrating the extraordinary change in the rate of price increases from year to year in the ratesetting States. The six States, Maryland, Massachusetts, Connecticut, New Jersey, New York, and the State of Washington, have consistently, through the regulatory period since 1976, outperformed the United States. The results have been a lower rate of price inflation for a day of hospitalization, a lower rate of cost inflation for the entire visit or admission and, more importantly, a reduced rate of increase in the per capita cost for the State throughout the regulated area.

The third point I want to make, which is made by figure 1 in my prepared statement, is that the etiology or the coming of State regulation cannot be traced to the interest of any one particular group. Where it exists, it has come about in response to the urging from, in some States, the Governor's office or the State budget office, and in other States at the insistence of the commercial insurance industry, which feels particularly discriminated against in certain States by rather significant discounts provided to Blue Cross payers. In other States, like Maryland, regulation came about at the insistence of hospital trustees concerned with the solvency of the industry.

Finally, we have seen a growing inclination of employers to urge regulation. This is an extraordinary move, I feel, because it represents the extraordinary frustration on the part of the Nation's employers with the hollow promises of returning to competitive solutions. Historically, these solutions have not worked, and theoretically should not be expected to work in an area where no market forces have ever existed. This is so because we have established hospitals expressly in the voluntary mode, so that we would not, in fact, have to use market forces to distribute care.

Another point I would like to make is that the Federal efforts today; namely, the Social Security Act amendments that relate to medicare, actually fly in the face of consistent public policy if our grand design is to, in fact, reform health care financing. The theory of the administration has been, as regards title 18 beneficiaries, that it will suddenly behave as a prudent purchaser of care. I would submit that this is rather irresponsible behavior because it denies the Federal Government's role in helping create the problem in the first place. It does nothing to bring about the fundamental reform in health care financing that is necessary, and does everything to induce hospitals not to change their behavior. It encourages the shifting of those costs unmet by the Federal Government to other payers, and there should be no mistake that this is happening.

I would close by saying that there is one bright ray offered by the statute which the Congress passed last year, this being a mandatory waiver proviso for new States that establish their own initiatives in regulating the hospital industry. This provision removes from the Secretary discretion in granting a new waiver that would provide that new State agencies would regulate the prices for all payers, including medicare.

I have been concerned in recent weeks with the growing sense that the Health Care Financing Administration, in administering this provision of the social security amendment, is inclined not to grant waivers to new States. Since April 20 when President Reagan signed the law, three States have enacted comprehensive all-payer regimes. Those States are West Virginia, Wisconsin, and Maine. I think it is imperative that the Health Care Financing Administration grant to these States the waivers that they seek, giving new stimulus to States to experiment and to devise their own system that would provide equity to all payers. This would provide security for the hospital industry, and would attempt to develop solutions on a State basis where the problem varies. From State to State, it would permit the Governors the opportunity to attempt to devise a rational system of solving fundamental problems in the States' hospital industry.

Thank you very much.

Chairman HEINZ. Dr. Schramm, thank you very much.

[The prepared statement of Dr. Schramm follows:]

PREPARED STATEMENT OF DR. CARL J. SCHRAMM

Good morning. It is a privilege to come before you today to discuss the problem of hospital cost inflation and what can be done about it. I am particularly pleased to have been asked to concentrate on the initiatives that several States have undertaken to reduce the costs of health care.

The problem of rising hospital costs have been of importance for over 50 years. It is an enormously complex problem; one which does not yield to easy understanding much less easy solution. Indeed, our theoretical understanding of the forces causing hospital costs to rise is limited. The process of designing programs to solve the problem is confounded by the ever-changing nature of the problem. But, the real difficulty lies in the dual nature of the various forces which are contributing to the problem. Hospitals, for example, play an absolutely necessary role in the process of delivering care. We know, however, that our unnecessarily large hospital system, with more capacity than we need, seems to be able to prevail over all levelheaded attempts to reduce its size. The reason is that the decision to reduce excess capacity must be made on a hospital-by-hospital basis and that any given hospital is a critical part of its community's economic life. To shut a hospital is to cause economic dislocation. To truly make progress in containing health care costs we will be required to make decisions which will result in significant economic disruption of existing patterns. All such efforts will be resisted mightily, as you know, by the many and powerful interest groups which have a stake in the continued growth of the health care enterprise in the United States.

Let me offer what I believe are the major reasons we have experienced the inordinate rates of hospital cost inflation we have seen in the past, accompanied by, and in part causing, the major shift in real resources in our economy into health care. (As you are well aware, we now spend over 10 percent of real GNP on health care as compared with about 5 percent in 1965.) The first is the radical change the medicare and medicaid approach to reimbursement wrought upon the economics of the entire health care system. By adopting a retrospective method of paying for all reasonable costs incurred in the delivery of care, and by permitting hospitals and physicians the authority of determining what is reasonable, the Federal Government became the single most important force in the demise of the ethic of cost consciousness which attended the voluntary health delivery institution since its invention in the Middle Ages. Once the Government covenanted for the care of the poor and elderly, the historic object of the charitable institution, there was no reason to operate within the cost-conscious, penurious constraints which were once enforced by the trustees of the Nation's hospitals when they were at risk for their economic behavior.

Second, the exponential growth of technology and innovation in the practice of medicine has created a wholly different kind of pressure on costs. Technology has revolutionized the practice of medicine and surgery. Many new diagnostic and surgical procedures exist which were not available 15 years ago, as a result, it is easy to say that the very nature of the problem is different. Physicians find technology-intensive practice more stimulating and more lucrative. Patients believe that medicine practiced with machine support is better and insist on many procedures which even their physicians feel are of marginal value. Finally, the beneficiaries of the technological age of medicine are the many firms which invested in the development and manufacture of the equipment. Under the modern reimbursement system, all reasonable costs are acceptable to the payers and technology became the very essence of reasonable practice in the 1970's.

Finally, and related to the above two reasons, the problem of hospital cost inflations appears intractable because so many more people have become dependent on medicine and health care as the source of their incomes and livelihood. During the past decade, marked as it was with stagnation and slow growth, no other sector of the economy grew faster than health care. Indeed, this sector seems totally isolated from the economic forces which affect the rest of the economy. As a result, health care has become a stabilizing force in the economy and has enriched many professional and paraprofessional groups which will not brook any reduction in the size of this industry without a bitter struggle. Moreover, the struggle will be difficult for political leaders. The medical establishment will portray every reduction in resources as threatening to the quality of care provided by the delivery system, and how can one question their professional judgments? In the next 10 years we will experience a 26-percent increase in the ratio of physicians to 100,000 population, adding enormously to the pressure to produce more medicine in order to maintain sufficient resources flowing into the health care system.

Faced with these pressures and without any sense of an emerging solution coming from Washington, 11 State governments have acted to regulate hospital cost inflation. Generally, these approaches treat hospitals as if they were public utility companies.

The State agency charged with keeping hospital costs under control within the jurisdiction generally approves a budget for each hospital. The budget is established prospectively, so that the hospital knows just how much money it will have at the beginning of the year. Faced with a fixed budget, the cycle of cost-plus reimbursement is broken and the hospital's management, and eventually its physicians, make decisions with an eye to their economic impact on the hospital's overall fiscal condition. Because, in most States, all payers must pay the same approved price for care in any given hospital. The State agencies can build into the price structure a surcharge for support of indigent patients not covered by any form of insurance and thus protect the hospital from bad debt. This feature is especially useful in attempting to protect inner-city hospitals with large patient populations who are poor.

These State initiatives, while they are similar in the approach they adopt to limiting the aggregate budget within their jurisdiction, emerged from a wide variety of concerns. Examining those States which have adopted hospital regulation, certain patterns in the legislative process appear to obtain. In some States the urgency of containing the State's medicaid budget has been the most important force in the development of hospital regulation. In others, concern on the part of trustees over the solvency of inner-city hospitals leads to legislation. In still others, concern on the part of commercial insurers and Blue Cross plans that hospitals facing inadequate payment levels from the medicare and medicaid programs would shift shortfalls onto other payers was the most important factor in establishing State regulation. More recently, groups of employers, concerned over rapid increases in hospital insurance costs, have urged State legislatures to enact new hospital ratesetting legislation. As figure 1 indicates, in addition to the different primary forces militating for State regulation, various other parties appear to join with others in predictable ways in forming effective coalitions for legislation.

Just as certain parties often provide the impetus for regulation at the State level, it is interesting to note that others invariably oppose State regulation of hospitals. State medical societies as well as State hospital associations (made up of professional administrators and not trustees) always oppose the development of regulation. In only isolated instances has Blue Cross or Blue Shield assumed a neutral posture, being mostly opposed to regulation. While organized labor has assumed a neutral to negative stance on the issue in the past, recent legislation has enjoyed labor support. This development mirrors the change in the posture of business as reflected in State chambers of commerce and similar business lobbies. In no States have consumer groups been the prime movers, a predictable situation is a fully insured system.

The performance of these regulatory programs has been very positive. As figure 2 shows, in the six States which first enacted legislation providing for mandatory regulation of hospital prices, per capita increases in total hospital expenditures have grown at significantly lower rates than for the Nation or for these same States in the preregulatory period. The difference in the rate of inflation has accounted for the savings of millions of dollars to the Federal and State governments in smaller outlays for medicare and medicaid, to employers, and to individuals responsible for purchasing hospital care directly. The conclusion that is unavoidable, viz, that hospital regulation works, bothers many people in an era when government initiative is thought to be the single-most cause of America's economic trouble. Many interest groups have labored hard to discredit these findings. Nevertheless, the strength of the relationship between government action and significant reductions in the rate of change in expediture on a per capita basis is certain.

It was this very relationship which lead the Congress to include in the amendments to the Social Security Act passed last spring and signed into law by the President on April 20, a provision permitting States the option to establish new regulatory efforts and for the Federal Health Care Financing Administration to cede to these newly established State agencies the authority to set prices for medicare services within their jurisdictions. Stimulated by this language, three States (West Virginia, Wisconsin, and Maine) have enacted comprehensive State hospital regulating laws and will seek the medicare waiver permitted by the new Federal law. From their recent pronouncements, highly placed officials within the Health Care Financing Administration have indicated their intent to deny these waivers, in direct contravention of a Federal statute that was designed to make the matter of receiving a waiver an automatic event when certain conditions, specified by Congress, are met by the States. Should the administration proceed to act in such a manner it will be pursuing a misguided and ideologically inspired course of conduct designed to affirm an anticompetitive bias in the face of a workable and practical State level solution.

I would like to close by noting that where State regulatory efforts worked successfully it has been because of the continuing commitment of Governors, hospital administrators and trustees, and insurance companies working together for the common good. I know that in the States with waivers in place, granted previously under experimentation and demonstration authority, the Federal Government has had an active role in this interesting episode on the road to developing a pragmatic solution to the problem of runaway hospital inflation. This leadership should continue so that States will continue to develop new approaches which can have an impact on the problem in both the short and long run.

FIGURE 1

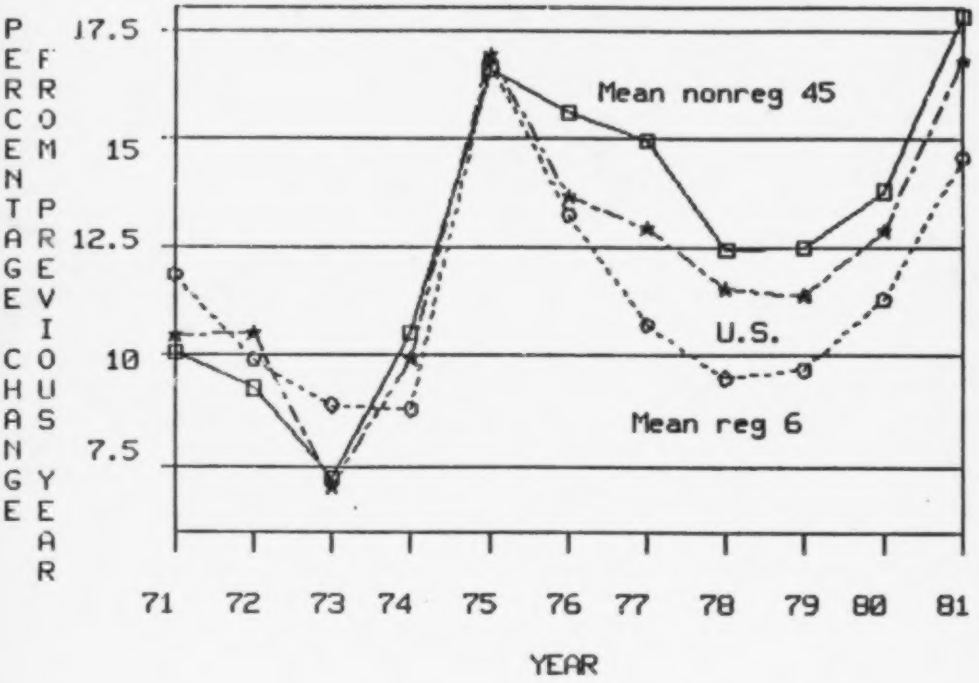
FORCES IN BRINGING ABOUT STATE REGULATION OF HOSPITALS

PARTIES OBSERVED TO INITIATE LEGISLATION	PARTIES JOINING LEGISLATIVE COALITIONS
	BLUE CROSS
STATE BUDGET OFFICER/ GOVERNOR	BLUE SHIELD
	AFL-CIO
COMMERCIAL INSURORS	CONSUMER GROUPS
	COMMERCIAL INSURORS
HOSPITAL TRUSTEES	GOVERNOR'S OFFICE
	HOSPITAL TRUSTEES
EMPLOYERS	HOSPITAL ADMINISTRATORS
	CHAMBER OF COMMERCE

FIGURE 2

PERCENTAGE CHANGE IN

EXPENSE PER ADMISSION (ADJUSTED)



Chairman **Heinz**. Dr. Morone.

STATEMENT OF JAMES A. MORONE, PH. D., ASSISTANT PROFESSOR OF POLITICAL SCIENCE, BROWN UNIVERSITY, PROVIDENCE, R.I.

Dr. **Morone**. Thank you for inviting me. I am delighted to be here.

I will summarize a couple of points from my prepared statement on the lessons of New Jersey in the establishing of an all-payer system.

New Jersey took the first steps toward an all-payer system with controls on just medicaid and Blue Cross in 1974. The results were clear and immediate. Hospitals shifted the costs to other payers, the unregulated payers. You cannot go anywhere in New Jersey without hearing about the balloon that Senator Heinz described earlier. Squeeze one end, and all the air—the hospital costs—rush to the other end—the unregulated payers. I do not think I have ever talked to anybody in New Jersey without the balloon coming up.

Within 5 years, Blue Cross, by its own estimates, was paying 30 percent less for similar kinds of patients in similar kinds of hospitals. This put the commercial insurers in a tough situation.

The real trouble came for the urban hospitals. They had many patients covered by medicaid and Blue Cross, and those patients were now paying less. They also have many indigent patients who do not pay at all.

Now, traditionally, the costs of those patients are split among the other payers. But with Blue Cross and medicaid being squeezed, the urban hospitals had no one to pick up the costs. This caused enormous problems for those urban hospitals. Between 8 and 15 were thought to be on the verge of bankruptcy. The only hospital left in Paterson could not afford mops, and for all this trouble, inflation continued.

Now, most of the major political actors were looking for a solution to the inflation problem. But the cost-control program that passed, only passed when cost control was linked to saving the urban hospitals. That seems to me to be the political key.

The new system that had been devised and was being fought over, was one that would set prices for all payers by DRG's. The change that got the program through was to include in that price the cost of treating people who do not pay, the indigent patient. That was a clear signal to the urban hospitals: You can get help from this program. It immediately split the hospital association, which had previously opposed an all-payer system.

The urbans now demanded the program. This was salvation. That was the key to passage. It then went through the legislature relatively easy.

The all-payer DRG plan promised to both save costs and save the urban hospitals. That is why it was enacted in New Jersey.

All kinds of other factors facilitated passage and development of new systems in New Jersey: A constitutionally powerful Governor was committed to the program. He delegated health policy to the department of health, which had no bureaucratic competitors pushing alternative proposals.

In addition, the legislature is constitutionally weak, which gave opponents less opportunity to derail the program—a contrast to a State like Colorado, where a similar system was repealed. There are no for-profit hospitals to oppose this all-payer system in New Jersey. The physicians were opposed to it, but they did not make that opposition clear until after it had gone through the legislature and been signed by the Governor. This somewhat diminished their effectiveness in New Jersey.

All these factors made it easier to get the all-payer system in place. I mention additional factors in my prepared statement. Obviously this particular combination of political factors is not going to exist anywhere else.

But it seems to me there are other factors that can exist in other places and will help other States establish all-payer systems. The first one I point to—and this is an old cliche—is money from the Feds. New Jersey thought the medicaid and medicare waiver they were going to get would be worth $60 million. You constantly heard reference to that $60 million.

In fact, right before the bill was reported out of committee, people apparently turned to the department of health officials and said: "Are you sure we are getting that $60 million?" In the legislature, in the implementation, you constantly heard $60 million for New Jersey. Although where that figure originally came from, no one was able to say.

It was important because it permitted a cost-control program to be introduced as a program bringing money to New Jersey, and it is always hard to turn down dollars. Now, of course, I am not saying if the same sweetener were widely available it would assure all-payer systems in other States. But it certainly facilitated passage through a number of key points in New Jersey's political process.

I would point to one last thing, and that is that an awful lot of States face very similar problems: Tightening controls on medicaid and Blue Cross, indigent patients who do not pay, urban and rural hospitals with serious financial troubles, and of course the inflation that is driving everybody crazy.

An all-payer DRG system that pays for patients who do not pay may look increasingly attractive because it not only appears to cut hospital costs, but at the same time it helps the urban hospitals, the hospitals that are treating poor patients. That seems to me to be a very rare combination. Finally, the all-payer DRG system promises to do so, not in some distant future, as some of the competition bills promise to do, but quite soon after going into effect—given the usual caveat that it is properly administered.

Thank you very much.

Chairman HEINZ. Thank you, Dr. Morone.

[The prepared statement of Dr. Morone follows:]

PREPARED STATEMENT OF DR. JAMES A. MORONE

In 1980, a new way of computing hospital payment was introduced in New Jersey. All hospital procedures were broken into 467 categories (called diagnostic related groups), and a price set for each. That fixed price was set by the department of health for all payers. I will describe some of the pressures that led to an all-payer system in New Jersey, then speculate about the likelihood that other States will introduce similar innovations.

The first thing to strike many observers about the evolution of hospital payment methods in New Jersey is the rapidity with which they changed. In 1973, hospital budgets were being reviewed by the New Jersey Hospital Association; 5 years—and three payment methods—later, the department of health was setting rates for all payers and all acute care hospitals. As one hospital official later described it, "I felt as if we were driving on a twisting road with accelerator nailed to the floor."

THE EVOLUTION OF AN ALL-PAYER SYSTEM IN NEW JERSEY

The movement to an all-payer system began shortly after Bryndon Byrne became Governor in 1974. In order to cut their medical program costs, the department of health began to regulate the hospital payments made by medicaid and Blue Cross. (Blue Cross was included because the State is responsible for approving Blue Cross premiums, and was under considerable public pressure to keep the rate hikes small.) Department of health officials worked hard to keep medicaid and Blue Cross payments down. For example, the target increase in 1975 was 7 percent. In contrast, the hospital association had permitted increases averaging 10 percent without negotiation throughout the 1960's. The consequences were swift and dramatic.

Blue Cross and medicaid payments were tightly controlled. However, hospitals protected their cash flow by simply shifting costs to the unregulated payers, particularly the commercial insurance companies like Prudential and Connecticut General. The ubiquitous metaphor likened the State effort to squeezing one end of a balloon. All the air (the hospital costs) simply rushed to the other end (from medicaid and Blue Cross to the commercial insurance companies). The general inflation in hospital costs continued. However the difference between what regulated and unregulated payers paid hospitals for the same patients reached 30 percent within 5 years. The other insurers were heavily subsidizing Blue Cross and medicaid. Obviously, Blue Cross enjoyed an enormous competitive advantage for selling insurance.

The different rates paid by the different payers also had dramatic consequences for the hospitals. The larger the proportion of commercially insured (and therefore, unregulated) patients, the easier it was for a hospital to recoup from late or unsatisfactory rate review decisions. Since medicaid and Blue Cross were paying less than the average price of treating patients, hospitals became heavily reliant on patients covered by unregulated payers.

Furthermore, most hospitals had indigent patients who could not pay the full cost of their care. Their costs had traditionally been apportioned among the other payers. However, the rate review system now protected Blue Cross and medicaid from this cross-subsidization, and medicare would pay only for its own patients. The burden of paying for those who could not also had to be shifted to the unregulated payers.

The problem was that the financially desirable, commercially insured patients generally live in the suburbs, the medically indigent crowd into the inner-city hospitals. Urban hospitals simply had no one to shift their costs to. They could not turn people away, but they were not being reimbursed for treating them. The partial regulatory system, exacerbated by a tight medicaid program and New Jersey's comparatively impoverished inner cities, set between 8 and 15 large hospitals on the verge of collapse. The chief executive officer of the only hospital that remained in one city recalled fearing that any of a score of creditors might have shut the hospital down by demanding payment. The hospital could not even afford new mops.

In short, a tight but partial regulatory system created enormous problems. While most hospitals resented the bureaucratic delays that came with the regulation of prices, some were pushed to the verge of ruin. Commercial insurers and those who paid their premiums were placed in a difficult situation. And for all the trouble, hospital inflation continued.

In 1976, the department of health moved to slow inflation by extending its rate-setting authority to all payers, thus cutting off the hospital's cost shifting safety valve. The hospitals, supported by Blue Cross, strenuously objected. The first years of government controlled reimbursement had been trying; there had been lengthy bureaucratic delays and enormous confusion. The hospitals fought hard to prevent any extension of State power over their budgets. In the end, the proposed changes were easily defeated. The bill was never reported out of committee. However, with very little fanfare, the Health Care Financing Administration (HCFA) gave the New Jersey Department of Health a $3-million grant to gear up for an experimental effort at setting prices by the case for all payers—that is, for a program much like the one in the legislation that the department of health had submitted.

Two years later, the department of health tried again. Cognizant of their earlier defeat, they made numerous concessions to the hospitals. However, one change in particular, threw over all prior political calculations. When the State set the price for all payers, it would factor in the cost of the patients who could not pay for hospital services. The medically indigent would no longer constitute a burden—they would be paid for, and at the same price as everyone else. The proposed change was an unambiguous offer of salvation to the urban hospitals.

Once again, the hospital association prepared to fend off what many of its members considered another intrusion by the government, one that would stop up their cost shifting safety valve and place them in a system where all prices were set by the State. However, the urban hospitals would not permit opposition to the bill. They had been in terrible financial trouble; now that help was being offered, they were anxious to get it. Rumors of a split hospital association began to circulate. Two years earlier, a united hospital association had defeated a similar proposal. Now a split association could only bargain for the best terms they could get.

Numerous political interests supported the department of health's bill, S. 446. Officials from the inner-city hospitals provided dramatic legislative testimony. The unregulated commercial insurers joined the coalition, their actuarial tables forming a sober counterpoint to the dramatic stories of life in the inner-city hospitals. HCFA also played a crucial role, promising a waiver on the normal method for computing medicare payments. It was thought that the medicare waiver would be worth up to $60 million for New Jersey. The $60 million (which ultimately failed to materialize) was mentioned repeatedly throughout the hearings on S. 446. Blue Cross, faced with defending a price differential of 30 percent extracted some concessions and went along. In the end, the legislation passed easily. Beginning in 1980, the State would set hospital rates for all payers, factoring the cost of patients who did not pay their bills into the prices of hospital services.

Note how the actual passage of the bill turned on a point that was not central to any of the key actors. The department of health sought to assist the urban hospitals, but that was not its primary motivation. The urban hospitals had been ignored the first time the legislation was submitted. HCFA supported the legislation, but it was seeking an experiment in cost control, not assistance to public hospitals. Nor was saving their urban members the primary goal of the hospital association which was fighting for the autonomy of the New Jersey hospitals—the issue was thrust on them when the urban hospitals threatened to split with the association.

Insofar as there is a key to the emergence of a new system in New Jersey, it is the plight of the urban hospitals. Though it appears to be one of many elements in the political backdrop, it was a crucial component of both the new payment scheme and the politics with which it was introduced. The major actors—the department of health, the hospital association, HCFA—were not seeking a solution to this problem per se. But it was a problem that desperately needed to be addressed. Furthermore, it is a problem that many urban States face, one that could be exacerbated by the new medicare which, like the old New Jersey system, seeks to cut health care costs with controls on only some of the payers.

The dynamics of change in New Jersey are clear: The State took firm control over rates paid by some of the payers. Driven by budget pressures and health system inflation, they used their new leverage to limit payments to hospitals, perhaps to a rate below the marginal costs, certainly to one below the average per patient cost of operating a hospital. Patients under the regulatory umbrella were paying strictly limited amounts. A substantial number of other patients—the medically indigent—were paying nothing at all. Hospitals could refuse to treat the underpaying and nonpaying patients. Or they could shift the additional costs to patients whose rates were not limited by State regulation—the commercially insured, the self-payers. Thus, the celebrated balloon. However, there were limits to this strategy. Some hospitals had too many nonpayers spread over too few privately insured (nonregulated) patients. Inevitably, those hospitals began to go broke. The dynamic applied to even the most efficient, though bad management would bring the crisis on sooner. The unregulated began to clamor for regulatory protection.

HOW TYPICAL IS NEW JERSEY—ADOPTING ALL-PAYER SYSTEMS IN OTHER STATES

One major question about New Jersey's all-payer system is whether other States are likely to pursue a similar course. To help assess the possibility, I'd like to point to some of the political and institutional developments that were important to New Jersey's reform, and consider whether they are likely to be present in other States.

The Federal Government, specifically HCFA, was essential to the development of an all-payer DRG system in New Jersey. Without the Federal grants and a Federal medicare and medicaid waiver, it is quite likely that the program would never have been started. The State personnel that developed the program were paid for largely by a Federal grant; the program cost the State of New Jersey very little. The existence of startup money and the expectation of up to $60 million from the waiver eased both the development and the passage of the program. The belief that the new system would be relatively painless in the short run and lucrative for New Jersey in the longer run was extremely important for diffusing opposition and gathering support.

Furthermore, the Federal officials repeatedly proved a convenient scapegoat for the department of health when it was criticized. For example, the rapid timetable was repeatedly attributed to the demands made "by the Feds." An even more striking example occurred when opponents of the program sought to halt implementation on the grounds that the department of health had exceeded its authority—DRG's had never been mentioned in the enormously cryptic legislation (some officials claimed that it had actually been struck from an earlier draft to avoid controversy). Some of the legislators were understandably annoyed. This was the first time most of them had been told about DRG's. Hearings were scheduled. However, before they could be completed, HCFA officials intervened. They were interested, they said, in an experiment in which all prices were set by DRG's. Without it, HCFA would not grant a waiver on medicare payments; without the waiver, there would be no infusion of Federal funds to help cover the costs of uncompensated care; without payment for uncompensated care, the urban hospitals were back to their troubles. Later, the assembly passed a resolution, without force of law or any consequences, condemning the implementation of the bill they had passed. A Federal carrot and stick—the promise of additional money with an all-payer DRG system, the threat of no waiver without it—had stopped the critics from altering the program.

In short, Federal Government officials appeared at several critical points and played a key role in shaping events. And the expectations regarding the medicare waiver, along with the earlier grants, made it possible to sell a cost-cutting program as one that would bring additional funds to New Jersey.

The development of New Jersey's program was also facilitated by the State's constitutional arrangements. New Jersey has an extremely powerful Governor's office. He is the only important statewide elected official in Trenton. It is often said that he has more sweeping appointive powers than the Governor of any other State. Furthermore, not only does the budget originate from the administration, but the Governor has the power to veto individual line items.

This strong Governor is matched with an institutionally weak legislature. The legislators are not full-time professionals; they meet twice a week and have only limited time and expertise. Naturally, this is not a consequence of individual legislators—some, like State Senator Scardino, were widely admired for their role in developing the program—but of the New Jersey constitution, relative to other States, legislators in New Jersey are given limited means with which to play a circumscribed role.

Naturally, the legislation, S. 446, had to be enacted for the program to be developed. But the legislature is best viewed as the ratifier of agreements that had been worked out by the interested parties. The hospital association even went so far as to write a letter to the chairman of the assembly committee telling him that S. 446 was the product of delicate negotiations, that any modifications might upset the compromises, and that the assembly should pass the bill (already approved by the State senate) without amendments. In many legislative contexts this would have been considered presumptuous, even rude. In New Jersey, the assembly complied.

This balance of power—strong Governor, weak legislature—was crucial, for it made it very difficult for opponents to derail the program that the Byrne administration was committed to, especially once S. 446 had passed. In New Jersey, there were simply fewer access points from which to enter politics and fight the program. For example, that weak assembly resolution condemning DRG's (with no force of law or any impact) might have developed into a serious threat in a State with a more powerful legislature or a weaker Governor.

Furthermore, the Governor's power was not scattered among various executive agencies but concentrated in the department of health. Health policy was largely formulated there. This centralization of decisionmaking is not typical of State politics, and is not likely to be repeated to such a degree. The more usual competition among various State agencies is less pronounced in New Jersey and was particularly muted during this period. It was quite clear that the Governor had delegated authority over health policy to the department of health. Other agencies, the department of insurance or medicaid, for example, did not play a significant role or provide a challenge to the department of health's authority over rate review. Once again, the consequence was to diminish the checks and balances to officials developing an all-payer DRG system. And again, this may not be true in other States.

It should also be noted that the staff in the department of health was hard working, exceptionally able, and enormously committed—at times they viewed the system they were creating with a spirit that one of them likened to "a religious crusade." Nor should it detract from their commitment and skill to note that many staffers benefited personally from developing an all-payer DRG system. "They came to do good and they did very well indeed," noted one hospital administrator. These rewards may be important in thinking about diffusion to other States. Rewards, both in terms of personal ambition and social commitment are available. Others, elsewhere, may also see the potential to make both a difference and a name, and some of them may have the talent and the political backing to succeed.

Another key in the development of an all-payer system is the attitude of the hospital industry. It is hard to imagine it being imposed on an industry that was completely and uniformly opposed to it. An important element of New Jersey's innovation was the board legitimacy that was accorded the public role in hospital affairs. Though there was a great deal of political conflict, the general idea of regulation and the more specific idea of an all-payer case-mix system had been tolerable to the industry (though they by no means endorsed all the details).

Still, despite the enlightened leadership of the hospital association, the fundamental key to the hospital's support—probably the key to the entire reform—remains the problem of the urban hospitals. Recall that a united association had blocked the department's first effort in the legislature before the problems of the urban hospitals had been addressed. As noted above, hospitals with too many indigent patients and not enough unregulated payers on whom to shift costs, were in deep financial trouble. Many hospitals found themselves in the anomalous situation of needing the State to control their total revenues. Hospitals needed the State to control all the payers or none. As controls on medicare and medicaid are tightened, similar pressures are likely to be felt in inner-city (and perhaps rural) hospitals around the country.

Finally, the introduction of an all-payer system was facilitated in New Jersey by the absence of three political interests that might be expected to take an active role elsewhere—physicians, teaching hospitals, and for-profit hospitals.

An all-payer DRG system could not have been introduced in New Jersey without a great deal of technical help from individual physicians. However, despite an enormous potential stake, physicians as a group, exhibited an astonishing absence as the politics of introducing the system were played out. While many other interests battled over the contours of the system, the medical association was nowhere to be seen. They finally took a stand against the legislation—after the bill had been passed. There may be many reasons for this abdication—the system does not immediately work on physicians. Hospital payment schemes seem to change monthly, why should another variation matter? Or perhaps physicians were divided along with the hospitals that they serve in. Whatever the cause, physicians greeted the introduction of a system that could have sweeping ramifications for their profession with an extraordinary political quiescence.

Second, there was only one major university teaching/research hospital in the State, and it was in financial difficulty due to large volumes of indigent patients—exactly the problems that the all-payer DRG system was designed to address. Since teaching hospitals get more complicated cases, even within specific diagnostic groups (or DRG's), passage and implementation of the new system would have been complicated by a large number of teaching hospitals in the State. It would not have presented insoluable difficulties, but the absence of opposition from this quarter facilitated the task in New Jersey.

Third, and far more politically important, New Jersey had no significant investor owned, for-profit, segment of the industry. While there is no reason to think that an all-payer DRG system could not coexist with for-profit medicine, it is likely that the profit sector would have strongly resisted the program and would have added many difficult questions to the implementation process (e.g., how should profit be handled?). In New Jersey, a profit sector might not have greatly altered the political outcome, given the limited number of significant access points to the political process. However, in a State with a strong legislature, the potential for for-profit hospitals or medical centers to either block similar programs or extract concessions must be recognized.

CONCLUSION

A great many forces were at work to facilitate New Jersey's transition to an all-payer system: A constitutionally powerful Governor, a comparatively weak legislature, a relatively centralized health policy, the absence of for-profit hospitals, the political quiescence of physicians. This combination is not likely to exist in many States. On the other hand, some important features I have described are very likely to appear elsewhere: The financial incentive provided by the Federal Government made a cost-control program appear like a way to increase revenues for the system; such incentives could certainly be enhanced in order to make similar systems attractive to other States. Furthermore, high and rising hospital costs, tightening controls on medicare, medicaid, and Blue Cross, financially troubled urban hospitals with no one to pay for indigent patients, and political entrepreneurs who are ambitious, dedicated, and skillful, all exist elsewhere.

All-payer systems that include the cost of indigent patients in their price-setting calculations may appear increasingly attractive, for they promise a solution to several different problems simultaneously: They appear to provide a solution to soaring health costs. However, unlike most "solutions," they seem to cut costs while actually assisting the troubled urban hospitals—as administrators from the New Jersey inner cities will happily testify. This combination places them on a very short list of alternatives. There are very few plans that appear to have the potential to both cut costs and assist the most troubled hospitals. The New Jersey system may be able to do both—and what's more, to do so not in some distant future (as with some health care competition plans) but very quickly after being placed into effect. That promise makes the spread of this innovation more likely, even where all the political factors do not line up as nicely as they did in New Jersey.

Chairman **Heinz**. Mr. Crosier.

STATEMENT OF JOHN D. CROSIER, WALTHAM, MASS., EXECUTIVE DIRECTOR, MASSACHUSETTS BUSINESS ROUNDTABLE, INC.

Mr. **Crosier**. Thank you, Mr. Chairman.

For the record, my name is John Crosier. I am executive director of the Massachusetts Business Roundtable. I have submitted some testimony,[1] and with the chairman's permission, I will summarize it.

The Massachusetts all-payer system was the result of a convergence of propitious circumstances, some over which the participants in a statewide coalition had some say; others, because of opportunities for Federal waivers, and in general, increasing awareness across the country of escalating health care costs. In Massachusetts we had had a 2-year effort by a combined group, the Legislative Reimbursement Commission, that failed because there was no incentive to move off the previously guarded positions of the various vested groups.

And the failure of that commission left two alternatives. It could maintain the status quo, or it could look for new opportunities to contain costs. The status quo was clearly not an acceptable option.

Four statistics might make one aware of the Massachusetts situation. The average health care bill in Massachusetts is 30 percent above the national average. The medicare program in Massachusetts is 25 percent per enrollee over the national average, medicaid is 52 percent above the national average. An average length of stay in the Massachusetts hospital costs 45 percent over the national average.

When the business community leadership learned those four statistics, they wanted to know what could be done about it. And looking around at what helped create the problem, they could point the finger at themselves. Because in designing expensive health care programs for the private sector, we had contributed to the problem. As hospital trustees, we had sat in hospital board rooms and voted to create our own problem.

---

[1] See page 46.

In the face of status quo, the business community formed a statewide coalition consisting of the Massachusetts Hospital Association, Blue Cross of Massachusetts, the Life Insurance Association of Massachusetts, the State government, the Massachusetts Medical Association, labor was involved on the fringes in the beginning and will now join the coalition as a full partner, and the the Massachusetts Business Roundtable representing the business community who had been paying the bill either through premiums or through taxes. Many companies in Massachusetts were receiving 20, 30, and 40 percent annual premium increases. And that was clearly creating competitive problems.

I would suggest that the phenomenon that went on in the private sector is now going on in the Congress and in State legislatures where the cost of medicare and medicaid is simply increasing to a point of the total budget to demand attention.

The opportunity for Federal waivers was the trigger point in Massachusetts that encouraged the Massachusetts Hospital Association to commit to the effort that is now underway. An all-payer system establishes essentially a playing field, freezing in place, if you will, cost shifting that had been permitted up until now, but not permitting any additional cost shifting. And if there is an Achilles heel in the Massachusetts program, it is care for the poor and near poor in the medicaid budget, and the inability for hospitals to pass along free care and bad debt.

There can be no finger pointing. There has to be realistic thinking to give up something. And I can tell you that the members of the coalition at the conclusion of the negotiation in Massachusetts were all displeased for one reason or another because they didn't think they got what they needed.

There is a reverse side of this. The private sector—and the public sector must do this as well—and that includes substantial benefit redesign, looking at tax implications, looking at behavioral changes, looking at utilization review techniques, looking at corporate giving and how trustees perform, developing a management information system that means something, being committed to a long-term course of change. Without that commitment, we do not think that there is a substantial opportunity for any meaningful long-term permanent change.

We think that an enormous educational effort is going to be required. Had it not been for the education that took place of the parties to that coalition that I outlined in the States that were in front of us, I don't think that we would have been successful in Massachusetts in passing what is one small step toward containing costs. It is not going to reduce costs. It is going to slow the escalation of costs.

If the Massachusetts system works, in 6 years we will have reduced the growth of health care costs only 7.5 percent over what they would have been.

I will close with the statement in my testimony, and that is, "We are not going to talk our way out of a problem we behaved our way into." Unless we are committed to develop what the alternatives are, I don't think there is a prospect for significant reform.

The other caution is that, as we look at an aging population that will increase dramatically in the next decade, and look at the demands for open heart surgery, the demands on the system will increase. The question is how much can we see the rates increase without denying care to those who need it?

Thank you.

Chairman HEINZ. Mr. Crosier, thank you very much.

[The prepared statement of Mr. Crosier follows:]

PREPARED STATEMENT OF JOHN D. CROSIER

Mr. Chairman, members of the committee, I appreciate your invitation to testify today on "Controlling Health Care Costs: State, Local, and Private Sector Initiatives."

Mr. Chairman, your invitation was to speak to the experience of States with all-payer programs.

In Massachusetts, we have just completed our first year under a prospective cost-containment bill which, for the first time, produced incentives for efficiency and penalties for inefficiency.

BACKGROUND

The impact of substantial increases over recent years in health care costs as reflected in premium increases and Federal and State budget increases have caught the attention of a wide spectrum of public and private interests. In a nation accustomed to health care as an economic right without regard to cost, the hard realities of competitive pressures and public budgets financed by hard-earned tax dollars makes status quo as an acceptable alternative.

So what to do?

THE MASSACHUSETTS EXPERIENCE

Facts were hard to come by in assessing the relative health care cost situation in Massachusetts, so the Massachusetts Business Roundtable commissioned a study which, among other things, produced four very dramatic findings.

(1) Massachusetts health care expenditures are 30 percent above the national average.

(2) Medicare expenses per enrollee in 1979 were 25 percent higher in Massachusetts than in the rest of the Nation.

(3) In 1978, Massachusetts medicaid costs per capita were 54 percent higher than the national average.

(4) The average cost per hospital stay in Massachusetts in 1979 was 45 percent above the national average.

With premium increases outstripping by far inflation rates, the business community in Massachusetts became increasingly concerned about what could be done to check the rapid health care cost escalation.

One conclusion was obvious, and that was a better system had to be developed.

If Massachusetts did nothing and cost shifting continued, it was clear that the private insurance market would soon be unable to compete effectively with the Blue Cross organization in Massachusetts and we could be faced with the fate of New York, where the private market was driven out of the health insurance market. This, in effect, ended cost shifting and exposed hospitals to financial difficulty because of their inability to shift the unabsorbed portion of expenses to the private sector market.

WHY 1982

In 1982, the timing in Massachusetts was right for a change.

We had a business community committed to change. We had a State government recognizing that the status quo would spell trouble for the hospitals of the State, for the State budget, and the opportunity of a Federal waiver from medicare and medicaid provided a unique opportunity to try an all-payer system.

Regardless of the divergence of opinion surrounding the issues, there was general consensus that cost shifting needed to be arrested, incentives for efficiency needed to be installed in the system rather than the previous system of penalties, and that if the higher Massachusetts costs were to be dealt with effectively over a period of time, the size of the system needed to be gradually reduced.

ELEMENTS OF SUCCESS

Any program at the local, State, or Federal level should have several fundamental differences from the retrospective payment systems that we have traditionally embraced in the past.

Those elements are as follows:

(1) Efficiency should be rewarded in any prospective payment system, not penalized as has been the case in prospective payment systems. Historically, there has been no reason to save money in cost-based reimbursement systems, rather there has been an incentive to drive up volumes. The future will depend upon the gradual development of good competitive plans versus a more rigorous regulatory environment.

(2) Future effective cost-containment systems will depend upon vastly improved utilization review techniques that will demonstrate the economic advantage of IPA's, HMO's, and PPO's.

(3) Continuing pressures on Federal, State, and corporate budgets will demand a more rigorous examination of a variety of alternative delivery mechanisms as we all strive to slow the rate of growth of health care costs. A more equitable sharing of costs by all sectors is an essential ingredient of any future reimbursement system.

(4) A combination of Federal and State initiatives, like the prospective payment systems in Massachusetts and other States, coupled with the Federal initiatives, particularly in medicare, and the diagnostic related group (DRG) approach will merit close scrutiny as we all seek to try a variety of cost-containment mechanisms.

(5) For the first time, providers will be put into a competitive or reactive role as purchasers exert more control over how the delivery system operates. This will include a more visible presence of the purchasers in the political process as public policy is shaped around these issues.

(6) Federal and State initiatives in the area of the tax treatment of benefit programs are a potential influence on how the employer community develops its health care packages for its employees.

A WORD OF CAUTION

Any system should not seek change in a radical fashion, and for that reason experimentation in the sharing of health care costs should be gradual and carefully thought out. Any attempt by Federal or State governments to dramatically shift burdens will probably be met with rigorous voter reactions.

Ever since the beginning of medicare and medicaid, government has been inclined to promise more than it is willing to pay for, and as a result, the hospitals have been put in a position of cost shifting the unabsorbed portions of Federal and State programs to private payers. As we develop all-payer systems cost shifting will no longer be available as a relief, and hospitals, their trustees, and public policymakers alike will have to carefully reexamine the promises that government makes and be sure that they are prepared to pay their share of the bill in full.

One quote accurately sums up the dilemma we all face as we look for effective ways to contain the cost of health care, "We are not about to talk our way out of a problem we behaved our way into." The changes should be gradual and it is fair to predict that meaningful reforms of the type that are being discussed today will occur gradually over the next 5 years.

Chairman **HEINZ**. Dr. Sloan.

STATEMENT OF FRANK A. SLOAN, PH. D., EXECUTIVE DIRECTOR, HEALTH POLICY CENTER, VANDERBILT UNIVERSITY, NASHVILLE, TENN.

Dr. **SLOAN**. Thank you Mr. Chairman, and members of the committee, for inviting me to present my reading of the evidence on State efforts to bring about hospital cost containment and my views on all-payer hospital savings programs.

I am a professor of economics at Vanderbilt University and also director of the Health Policy Center of the Institute for Public

Policy Studies there. I have personally conducted several studies of hospital costs, ratesetting programs, other hospital programs, hospital cost shifting, and studies of related subjects.

I first want to look at a few of the findings on ratesetting, and then discuss the implications, and then briefly say why I oppose all-payer ratesetting.

On the findings, the variety of hospital regulation programs were implemented at the State level in the 1970's and early 1980's. Only one of these efforts has done anything to control the rate of growth in hospital expenditures, and that is the mandatory hospital ratesetting program. In fact, if one puts all the hospital regulatory programs together, PSRO's and certificate of need, as well as some of the voluntary ratesetting efforts, and the mandatory ratesetting efforts, hospital regulations, if anything, exacerbated the hospital cost-inflation problem during the decade of the 1970's. These programs, in the aggregate, did not reduce the inflation rate in this industry.

But we do have this one program, among the many, that seems to have done something, and therefore, it pays to focus upon it.

My estimates, and those of others, would suggest that mandatory ratesetting has reduced the growth in hospital expense per patient-day by about 2 to 4 percent per annum below what it would have otherwise been. The reductions in the rate of increase in hospital expenditures per capita population are at the lower end of the 2 to 4 percent range, about 2 percent.

The expense per capita population figure is more interesting because it includes the influence of the programs on hospital length of stay, and on hospital admissions, as well as the effect of these programs on per diem expense.

Now a 2-percent savings per year seems very small, but such reductions mount up when compounded over a number of years.

My best estimate is that 6 years after implementation, hospital expenditures in States with mandatory ratesetting programs are about 10 percent lower. That is a cumulative cost estimate, a cumulative cost reduction, as a direct consequence of mandatory ratesetting. Mandatory ratesetting programs have not reduced length of stay or hospital admission rates.

In fact, when the per diem is the unit of payment, ratesetting appears to have raised length of stay. Ratesetting programs certainly have not done anything to control utilization to date.

These programs have not been uniformly successful in controlling hospital costs. One study I conducted with a couple of coauthors suggested that the New York and New Jersey programs have been relatively successful, and some of the others, Maryland, Massachusetts, and Washington, relatively less successful.

Particularly pertinent to the work of this special committee is the role of medicare in all of this. In one study I conducted with coauthors, we found that medicare waivers to permit medicare participation State rate saving did not save medicare money. It is hard to see how medicare, which pays for such a relatively low percentage of the charges, can be equalized with the commercial insurers and still save medicare money, especially when the program is not working on utilization in any meaningful way.

Prospective payment is certainly a step forward. However, it should not be seen as a panacea.

First, recent statistical evidence demonstrates it takes about 2 years for the programs to become fully effective.

Second, there is a question whether the success can be replicated to States with different political climates other than the State which it has been implemented.

Third, is the utilization problem that I have already described.

Now, I oppose all-payer rate programs for these reasons, and I will just be very brief here.

First, an all-payer system eliminates competition on the basis of price. Why should a hospital and insurance plan that is able to achieve efficiency not be able to set its own price and sell its product for less?

Second, all care is subject to State control, every major issue about the allocation of hospital resources will become highly politicized.

If medicare controls cost, there will definitely be more cost shifting. I argue in my prepared statement that cost shifting is good because I see it as a way to stimulate the private sector to implement its own cost-containment initiatives, which it has been very reluctant to do to date. The fact that the indigents could be left behind is a concern to me. Indigent care teaching can be public funded, and ratesetting is only one way to do this. There are other approaches.

I will be happy to supply reprints of the articles cited in the footnotes of my prepared statement.

Thank you very much.

Chairman **Heinz**. Thank you very much, Dr. Sloan.

[The prepared statement of Dr. Sloan follows:]

PREPARED STATEMENT OF DR. FRANK A. SLOAN

I. INTRODUCTION

Thank you Mr. Chairman, and members of the committee, for inviting me to present my reading of the evidence on the effectiveness of cost-containment programs developed at the State level in general and my views on all-payer hospital ratesetting programs in particular. I am professor of economics and director of the Health Policy Center, Institute for Public Policy Studies, Vanderbilt University. I speak from my experience as a researcher who has devoted most of my professional life to these issues, and as one who has been a consultant to several government agencies and private groups involved in one capacity or another with health care cost containment. I have conducted several studies of hospital ratesetting programs.

There has been a substantial amount of statistical research on the effects of ratesetting programs as well as on other programs designed to reduce the rapid rise in expenditures on hospital care. I shall first briefly review major findings from studies by me and others. Then I shall discuss policy implications of this research. Although hospital ratesetting may have a variety of effects, my remarks will focus on cost-containment aspects.

II. FINDINGS

A variety of hospital regulation programs have been implemented during the last decade and a half. Only one of these, mandatory hospital ratesetting programs has actually shown some promise in hospital cost containment. Hospital ratesetting programs not established under State law, but rather implemented by the private sector have not achieved cost savings. Nor have State certificate of need programs, section 1122 programs, or professional standards review organizations been effective in this regard. Both section 1122 and PSRO programs were authorized under the

1972 Amendments to the Social Security Act.[1] In fact, considering the effects of all hospital regulatory programs together, hospital regulation, if anything, exacerbated the hospital cost-inflation problem during the decade of the 1970's.[2]

Mandatory hospital ratesetting programs have reduced the rate of growth in hospital expense per adjusted (for hospital outpatient activity) patient day from 2 to 4 percent per annum on average in the States with such programs. Mandatory ratesetting programs have had a slightly smaller effect in reducing the growth in expense per hospital case in these States. These programs have reduced the rate of increase in expense per capita population in these locations by about 2 percent annually. The expense per capita figure is the most interesting because it embodies the influence of these programs on both hospital length of stay and admissions.

A 2-percent-a-year savings seems small, but such reductions mount up when compounded over a number of years. Unfortunately, it is too early to tell over how many years annual reductions of 2 percent can be achieved. My best estimate is that, 6 years after implementation, hospital expenditures in States with mandatory ratesetting programs are about 10 percent lower on average as a consequence of such regulation. The reason my estimate is only 10 percent is that the programs have achieved less than 1 percent per year reductions in each of the first 2 years immediately following implementation.[3]

Mandatory ratesetting programs have not reduced either length of stay or hospital admission rates; in fact, when the patient day is the unit of payment, they appear to have raised length of stay.[4]

Ratesetting programs have not been uniformly successful in hospital cost containment. According to a recent statistical analysis, New Jersey's program and New York's after 1976 showed the most notable reductions. The Maryland, Massachusetts, and Washington programs have been equally effective in achieving reductions in per diem expense, but they have done less well in lowering expense per capita population.[5]

At least through 1980, medicare waivers to permit medicare participation in State ratesetting did not save medicare money.[6] Two States, Maryland and Washington, obtained medicare waivers in the period before 1981. The most likely explanation for this finding is this: Combining medicare with other payers means that medicare payments must rise to achieve uniformity among payers. Uniformity is achieved by relaxing certain limitations in costs subject to medicare reimbursement. From the vantage point of Federal expenditures, a better policy is "to go along with the free ratesetting ride" than to join such programs and be bound by a common payment methodology. Unfortunately, there is no post-1980 evidence on the cost implications of medicare waivers.

Mandatory ratesetting has not adversely affected hospital profit margins.[7] Profit margins were negative or at most slightly positive on average in States with mandatory ratesetting even before they implemented their programs. This is not to say that profit margins have been adequate in these States. A normal rate of return on capital is appropriately treated as a cost rather than an element of profit.

III. IMPLICATIONS

Prospective payment is certainly a step forward. Retrospective cost-based hospital reimbursement is hopefully becoming a thing of the past. The major issue concerns the design of prospective payment programs.

Enacting a prospective payment program, however, should not be seen as a panacea. First, recent history has demonstrated it takes 2 years or so before these programs become truly effective in cost containment. One State, Colorado, made a strategic error in trying to make its rate controls operational too quickly. This mistake and others strengthened the hand of the political opposition, and Colorado's program was dropped.

---

[1] See Frank A. Sloan, "Rate Regulation as a Strategy for Hospital Cost Control: Evidence From the Last Decade," Milbank Memorial Fund Quarterly, vol. 61, No. 2, pp. 195–221, for a recent review of the literature as well as new empirical evidence on hospital regulation.

[2] Frank A. Sloan, "The Academic View," presented at George Washington University Conference, "Health Care Institutions in Flux: Changing Reimbursement Patterns in the 1980's," Sept. 23, 1983.

[3] Reference cited in footnote 1.

[4] Nancy L. Worthington and Paula A. Piro, "The Effects of Hospital Rate-Setting Programs on Volumes of Hospital Services: A Preliminary Analysis," Health Care Financing Review, vol. 4, December 1982, pp. 47–66.

[5] Michael A. Morrisey, Frank A. Sloan, and Samuel A. Mitchell, "State Rate-Setting: An Analysis of Some Unresolved Issues," Health Affairs, vol. 2, summer 1983, pp. 36–47.

[6] Reference cited in footnote 5.

[7] Reference cited in footnote 5.

Second, there is some question whether the successes can be replicated in States with greatly different political climates and much less expertise in regulation than the few States that implemented mandatory ratesetting first.

Third, the programs to date have done nothing to curb admissions to acute-care hospitals. It will not be possible to reduce cost per hospital case much without adversely affecting quality of care by a perceptible amount. If both the number of cases and cost per case could be reduced, far greater savings could be realized without having to resort to substantial reductions in the quality of hospital care. Admissions can be reduced by implementing capitation plans, utilization review coupled with meaningful financial incentives for the reviewers to reduce low-benefit care, and some patient cost sharing which encourages patients to seek lower cost alternatives to the acute-care hospital when these alternatives make clinical sense.

IV. REASONS FOR OPPOSING ALL-PAYER SYSTEM

Federal and State governments should pay hospitals prospectively for hospital care delivered under the programs they control. Private insurers may choose to pay prospectively as well. But I oppose all-payer ratesetting systems for these reasons:

First, an all-payer system eliminates competition on the basis of price. Why should a hospital or an insurance plan that is able to achieve efficiencies not be able to set its own price and sell its product for less and thereby gain market share? The lack of price competition in turn is likely to stifle innovation in the delivery of hospital services.

Second, if all care is subject to State control, every major issue about the allocation of hospital resources will become highly politicized. Which institution, for example, is to get the latest equipment? Which procedures should be subject to reimbursement? Of course, payers and employers must make decisions about which procedures they will cover, but I greatly prefer a pluralistic situation which allows each payer to make such judgments.

Proponents of all-payer ratesetting say they prefer treating hospitals as public utilities. First, the natural monopoly justification of such regulation does not fit the hospital industry well. Moreover a careful reading of the literature on public utility regulation indicates that such regulation is hardly a "bed of roses." Consumerists lobby for low prices, even though this may mean higher prices for consumers downstream; the suppliers argue for higher prices citing increased operating costs and the need for higher profit margins to generate internal funds for investment. Meanwhile, the firm's owners benefit from the higher profit levels. Sometimes price regulation has been initiated with the objective of reducing price to consumers. But over time, such regulation has evolved into a mechanism to maintain a minimum price and thereby to rescue firms within the regulated industry from the supposed evils of "destructive competition." How long would it take for an all-payer system to transform itself from a cost-control mechanism to one which primarily offers price protection to individual hospitals and insurers? The beginnings of such protectionism is already evident as one listens to the reasons some hospitals and some insurers want an all-payer system.

Third, an all-payer approach almost inevitably would mean higher outlays for medicare and medicaid. The commercial insurance industry correctly states that medicare and medicaid now pay less for hospital care than they "should." To establish equal payment, it would either be necessary for commercial insurers to pay less, medicare-medicaid to pay more, or, most likely, some combination of the two. In the most probable case, medicare and medicaid would be asked to spend some more on hospital care.

A preferred scenario is the following: As medicare and medicaid implement their cost-control measures, hospital cost shifting becomes an increasing problem for the private sector. The cost burden finally becomes intolerable to the private sector, and employers and insurers exercise their creativity in implementing meaningful cost-containment measures of their own. "Cost shifting" is good in my view to the extent it will promote meaningful cost-containment initiatives. Perhaps the private sector has accomplished so little in this area to date because the cost-shifting burden has not yet become sufficiently bad.

In the long run, we will be better off with a pluralistic health care system with government programs used to insure that all citizens receive an adequate level of health care services.

Chairman HEINZ. I am interested in your comment that you are for cost shifting, not because it is good in itself, but because it forces political decisions to be made at the local level.

Is that really what you are saying?

Dr. SLOAN. That is my view, that when it becomes painful enough, employers use other routes. They will just say they have got to to do something, and then they will turn to PPO's and HMO's.

Chairman HEINZ. What you are really saying is that at the State level, and presumably by inference at the Federal level, there is no change without crisis, and therefore, a crisis must be achieved. Indeed, we must do nothing to forestall the crisis if we are going to get real change.

Now, Senator Grassley is a member of the Finance Committee, and we had the opportunity—which is probably a little too strong a word—of being in the midst of a social security crisis earlier this year and last. Do you really believe that the Federal Government, like a great supertanker moving down the Delaware River with a curve at the end, should wait until the last moment to try and change course, even though we may end up on the rocks if we do?

Dr. SLOAN. Well, I have more faith in the private sector. I would think that what will happen is throughout the country people will be seeing their fringe benefits rising for health care, and will demand change. So it would not come to a Federal crisis. I see many, many, many local crises.

Chairman HEINZ. In a sense, the policy that you suggest we follow is freeze DRG's where they are, indeed reduce them as soon as possible. That will force cost shifting from medicare to everybody else to such an extent that it will create an early crisis at the State level and solve the problem.

Is that not a logical concomitant to what you just said?

Dr. SLOAN. That is. I would not want to encourage medicare to go wild, to overdo it, and cut back irresponsibly. But what they have done to date is, in my view, very responsible. They have said we are going to take action, we are going to do something about this problem, and the rest of you are free to do so too.

Chairman HEINZ. Now, I have just described—if there is such a thing as a carrot and stick approach, I have just subscribed a stick approach, which is really sticking it on the States in a big way. Is there any carrot that the Federal Government is in a position to offer States in order to move to better methods of controlling health care costs?

Dr. SLOAN. Well, the State has direct control over a small piece of this, namely through its medicaid program. Really most expenditures is in the private sector. And I do not see so much of a carrot. I see the advantage of a tax cap which has had trouble passing. You might call that a stick, another type of stick.

Chairman HEINZ. Carrots are not in season?

Dr. SLOAN. We have had some licks, sir. We have had some from the Federal Government. And it would seem to me that the carrot here is the supply side, do the health care industries want to take some action in cost containment before the Federal Government acts forcefully? At some point there is going to have be a global solution if nothing is done.

Chairman HEINZ. Is it a fair summary to say that if the Federal Government was to pass legislation to try and encourage State level all-payer systems, that you do not, first, you do not think it is a good idea; and second, you don't think that no matter how sophisticated an array of carrots and sticks we might come up with, that you doubt that there are any real carrots, and the sticks would be a little heavyhanded?

Do I understand your position?

Dr. SLOAN. Yes; there are basically little sticks and big sticks.

Chairman HEINZ. Little sticks do not matter, and the big sticks are too heavy?

Dr. SLOAN. Right; but the middle sticks, the DRG's and if a tax cap could be enacted. There are a multitude of some moderate middle-level sticks I think would be very useful here. I have reviewed the literature on airline regulation and surface transportation regulation, and I am struck by the analogies to the all-payer-type system. It seems to me by going to all payer, we are getting into the same kind of problem areas that we have had in those kind of regulations where you have a lot of firms and where the firms mainly are concerned then, that one doesn't undercut the other and take away the best customers. You get into all those kinds of minimum price concerns, even though you start out with maximum price.

Chairman HEINZ. It is not clear to me whether we are in the prederegulation or postderegulation with respect to the health care system. Maybe we are in a different part of the curve, so to speak.

But you raise a fascinating question.

Let me turn to Dr. Schramm.

Dr. Schramm, Dr. Sloan has argued against much in the way of a Federal effort to do anything to stimulate more action at the State level. His argument is, fellows, you just can't do it, and indeed, some of your testimony suggests that there have to be certain political conditions at the State level. Indeed our entire panel has talked about political forces operating at the State level.

Do you agree or disagree with his conclusion?

Dr. SCHRAMM. Well, Senator, I basically disagree. I think without doubt there has to be political commitment in order for these programs to be successful. When stripped of the medicare payment and the Federal share of medicaid, around 60 or 65 percent of all the resources expended in the hospital industry still are generated in the community. Thus, the community still remains as the major force of political commitment in this area.

I think that this type of commitment should be encouraged from one of the payers, namely medicaid.

Chairman HEINZ. Now, do you think all-payer systems could be successfully replicated in a large number of State jurisdictions?

Dr. SCHRAMM. I certainly believe, Senator, that they will be tried in a great number. We are about to see a second generation of ratesetting unfold.

Now, whether it will be effective in every instance is another question. My sense is, even as a policy prescription, it will be more appropriate in some States than other States. The issue of whether or not it will be effective relates to the local forces that will be in place, and it seems that we will see a propensity for new forces urging legislation.

I don't think we have seen much consumer interest in the past, but we will see growing consumer interest in the future.

I think that the activities going on, for example in the State of Wyoming, are basically consumer based. I think the legislation in West Virginia was basically enforced by consumer interests. In addition to the consumer, I think there is much intensified pressure from employers in the States. Organized labor has also endorsed State legislation within the last couple of years. I think the constellation of forces that insures increased State activity is, in fact, growing.

Chairman HEINZ. If you had to guess, and over the next 2 or 3 years we do not do anything, are we going to see the kind of implementation in States across the board that is likely to make the kind of across-the-board health care savings, including savings for medicare, that is going to abort the medicare insolvency we face by 1988?

Dr. SCHRAMM. Well, Senator, I think you have asked two questions. If by "we," you mean if the U.S. Government, the Federal Government doesn't do something, will something else——

Chairman HEINZ. Well, according to Dr. Sloan, his prescription is if you do not do something, something will happen.

Dr. SCHRAMM. Right.

My sense is that the Federal Government in the executive branch takes a very hostile attitude toward State efforts, that is, if they say we will not participate in these State efforts, and this will be the most dampening step that I can imagine.

Chairman HEINZ. I imagine Dr. Sloan will agree with that.

Dr. SLOAN. It would be dampening by definition.

Chairman HEINZ. But you are in favor of the use of the waiver system?

Dr. SLOAN. I am not terribly in favor of it.

Chairman HEINZ. You are not.

Let me ask one or two main questions before I turn to Senator Percy and Senator Grassley, and let me ask this question of Dr. Schramm.

Dr. Schramm, what Federal actions do you believe would increase the willingness of the State government to adopt all-payer systems?

Dr. SCHRAMM. The States should be granted the waivers that they seek, assuming that the well-devised statutory conditions are met. The Federal Government should induce this action and provide technical assistance, and perhaps the waiver conditions could be relaxed so as to permit a longer time period to meet the cost performance standards. The longrun plan should be structured so that States will generate even stronger programs, thus resulting in savings for the medicare program.

I should just say that I do think there is contrary evidence to Professor Sloan's assertion that these medicare waivers have not saved money. I know that in Maryland, which was the first recipient of a medicare waiver, there is a statistical test established and binding on the States. This is contractually set out and signed by the Governor of our State, and provides that the waiver is lost if the cost to the Federal Government is higher in the regulatory period. We have met the conditions of that waiver for 7 years in a row.

Chairman Heinz. Let me just pose essentially the same question to Dr. Morone and John Crosier.

What can the Federal Government do to induce State governments to increase waiver programs? And what actions could increase the likelihood that such programs would be effective?

Dr. Morone. Let me start by saying I do not really believe in the spontaneous combustion of forces of good, that just leaving things alone will not necessarily mean that because——

Chairman Heinz. In fairness to Dr. Sloan, I think what he is saying is that if you can allow pressures to develop and absolutely increase them, it does force a reaction. I have always viewed, frankly, the first elements of pressure as a way of forcing the DRG's, and then the DRG's, in turn as a way of forcing a lot of other things to happen.

Dr. Morone. That is true.

Chairman Heinz. I do not consider it nothing, and I do not think he would consider it nothing. So just to put that into perspective.

Dr. Morone. I think winning this game ultimately means ending hyperinflation, not only for Government medical budgets but throughout the medical system. In the long run, a medicare waiver as part of an all-payer system could be an important component of doing that.

So I think you need to look at the waiver in the long run as well as the short run. And in the long run, I think it may be crucial to successful cost containment, as I believe an all-payer system, done right, can be a success.

It is not completely clear to me—in fact, it seems unlikely—that it does save the Federal Government money in the short run, since obviously you are putting an end to the shifting of costs away from Federal programs.

Chairman Heinz. Mr. Crosier.

Mr. Crosier. Mr. Chairman, I think if anybody is waiting for pressure to arise, I submit that it is here. I do not think we ought to wait any more. I think I have to disagree with Dr. Sloan, that to let cost shifting continue is going to wake up the private sector any more. I think cost shifting continues when the private sector pays for it. And now it is reaching the portions that it is, and the choice is insulate once from shifting, which is what the Massachusetts program does.

Now, I submit to you the pressure will shift from the commercial insurance interests to the hospitals. And now we are talking about people, not big, bad business. I would submit that a lot of statistics we are talking about are talking about hospitals and not doctors and people. And when we start talking about people, the interest is going to go way up.

The thing that concerns me is, if you let the cost of shifting phenomena go on to the extent that it did in New York State, you create a public problem by indifference to a situation that was pointed out long in advance of the New York crisis. It is what we tried to avoid in Massachusetts, and I would submit for the committee's knowledge, all we did in Massachusetts was freeze shifting where it is. The commercial still made a differential.

And what we succeeded in doing in the all-payer system, I would suggest to the committee, is create equity among the partners, private sector and public sector. And if we are not going to have equity, I do not see there is any hope for a resolution.

This is not a private sector problem; it is a society problem. And to indirectly tax is a sham on the American public. And I think that what we have gotten ourselves into is a predicament where we believe that health care is an economic right. And if that be the case, let society pay for it out of general revenues and not indirectly tax it, in what I submit, is a hidden shaft.

Chairman HEINZ. Just so I understand you, Mr. Crosier, and you, Dr. Morone, beyond the question of medicare waivers, not the mandatory ones, the discretionary ones, being more easily available, is there anything you believe the Federal Government ought to do at this point?

Mr. Crosier.

Mr. CROSIER. I think the Federal Government should encourage experiments. I do not think what works in Seattle will work in Baltimore. And I think they ought to provide exciting opportunities. I think the waiver States that are here now provide opportunities for some early evidence as to whether we are on the right track or not.

One statistic that is coming out of the Massachusetts experience—and we are just closing our first year under the cost-containment legislation—is that the average length of stay in the hospital is down a full day from 7 to 6. So there is movement. And I can assure you that as you build awareness on the part of trustees and physicians, utilization comes to the fore. And you create perceived and real pressures on the participants in the system, and the results are there.

And I do not think that there is any demonstration that quality or access has suffered in the first year of our experiment.

Chairman HEINZ. Dr. Morone.

Dr. MORONE. I think it could be a very exciting period we are going into, with a lot of different States moving into various kinds of experiments. It seems to me, beyond granting waivers, another thing that the Federal Government can do is to provide funds to develop experimental ways of setting rates. For instance, in New Jersey, the department of health started out with a $3 million grant to develop DRG's before anything had been legislated. You are in a position to help get different things going in different States. It will be interesting to do so, and be able to watch and evaluate the results.

Chairman HEINZ. Senator Percy.

Senator PERCY. Thank you very much, Mr. Chairman.

We have had a very valuable study presented to us this morning, which was made available by Mr. Taylor of Louis Harris. I believe that it is a fair, balanced, and comprehensive study. The people that they have talked to are recipients; they are not specialists in the health care field. They are, however specialists to the extent that they have fears, concerns, and experiences.

I wonder if you had heard the results of that survey, as I do not imagine you had seen it before. But as you heard it, having spent as much time and thought as you have in this field, would you concur that the majority opinion was the right opinion? Did you say, "Well, no, if they had only known what I had known, this is where they would have gone, this is the impression they would have had?" If that survey was presented to you, how would you have responded to some of the key issues?

Let us just go from left to right.

Dr. **Sloan**. Thank you.

I just have selected reactions. The survey was not an industry survey. It dealt with beneficiaries and voters. And they would have different views from the industry. And many of the items that we are talking about, all-payer systems, are much too technical to be included in the survey. One can only be very general with them, it would be hard to ask probing questions in this area.

I find it very interesting that the beneficiaries were not absolutely opposed to cost sharing or to cost-containment measures, that they were willing to do their part. This was very encouraging because I would not have known that.

Senator **Percy**. You are impressed with the fact they are convinced that, "There ain't no free lunch any more," that someone has to pay for it, and they pay?

Dr. **Sloan**. Very impressed by that. And I believe it was Senator Heinz who said, I guess it was, but anyway, the doctors' leaders might be very different from the doctors themselves. And in future surveys, it would be good to get beyond the leadership. Leadership in medicine has been extremely conservative. And hopefully out there there is more feeling that there needs to be some changes. And not all change should be opposed. I have been disappointed in the leadership.

Mr. **Crosier**. I am not quarreling with the presentation of the survey, but I think that it demonstrates the knowledge lag of the people who were surveyed and what the real world is all about. And what we should do is try to pass some of these costs around to some of the programs that are being proposed before the Congress, and we will get substantial shifts of attitudes.

I would suggest that the genie is out of the bottle as far as the physicians are concerned. It is going to be the year of the doctor next year, as we begin to burrow into utilization review, and that a lot of what doctors have been reluctant to do with peer pressure will now be done in the sheer weight of utilization statistics about where the abuses are in the systems.

I do not think it is fair to expect that the people are going to witness this change without protests, particularly when you ask them to pay more.

We did a survey in Massachusetts, and one of the interesting answers to a question was—would you be willing to forgo some pay increases in the subsequent bargaining negotiation for no loss of benefits in health care? And the answer was overwhelmingly "yes." The fact of the matter is—and you see it in the protests of the unemployed—that health care cost is such an economic threat to any family's income that they will sacrifice almost anything to make sure that that flank is not exposed.

And I think it is understandable as Federal or State policies just look at benefits, and look at the enormous increases, that they just are driven to the conclusion that we have to shrink the system.

Dr. **Morone**. I am struck at what seems to be a broad consensus for action on a whole lot of different fronts, right down to the willingness to accept increased cost sharing, which I too found surprising. It is striking how people seem ready for so many different types of initiatives. I am also struck, with Dr. Sloan, at how out of step with public opinion the physicians were. I would guess, if you charted that over the last 20 years, you would find a steadily growing divergence between what the physicians believe and what the general public seems to believe.

Dr. **Schramm**. I did not find much of it all that encouraging. I hate to be the prophet of gloom and doom.

As a professor, I am struck by studies that indicate that people answer Lou Harris surveys quite differently than they vote, particularly around public policy matters, which are not formed as to which candidate will you vote for.

The second thing that is very depressing is the physician responses. My own sense is that it does not reflect a gap in physician leadership versus regular physicians; I think it reflects the general attitude among physicians. I could not agree more with Mr. Crosier that we are, in fact, going to have an absolute crisis around the question of physicians in the United States.

But the crisis around physicians will grow even more acute when faced with the question of growth in the absolute number of physicians and physicians relative to the population.

We are about to have an extraordinary expansion of physicians in the next 10 years, coinciding with physicians beginning to shoulder the burden personally and financially in light of a general reduction in the commitment of per capita wealth to the health care enterprise. Perhaps the most cumbersome subsidiary issue that we hear is their attempt to resist change on the institution, that change will have severe consequences on their income position. That situation faces every physician in the United States no matter what happens.

Senator **Percy**. Thank you very much.

Senator, I know you and Senator Grassley have an 11 o'clock Finance Committee meeting. Dr. Morone, could you just tell us in one word, based on the New Jersey program, did your all-payer system result in savings or higher costs to the medicare program?

Dr. **Morone**. Too early to tell is the one word.

Senator **Percy**. Thank you.

Chairman **Heinz**. Senator Percy, thank you.

Senator Grassley.

Senator **Grassley**. Dr. Sloan, following up on your exchange with the chairman, is it your thesis that cost shifting, because of DRG, is necessary to bring about any savings? In this sense, are you saying that DRG's in and of themselves immediately will not bring about any savings?

Dr. **Sloan**. DRG's were designed to be cost neutral with TEFRA, so in a sense, the savings, at least in the foreseeable future, were not envisaged. However, TEFRA itself was a substantial cost-containment measure, and that was what brought about the DRG.

To me, the DRG is a step in the right direction and will ultimately result in some saving. But nothing compared to the $300 billion deficit in the trust fund which has been projected for 1995. In fact, the projection of the $300 billion deficit already incorporates an estimate of what the DRG's will be. So we have to do much more.

Senator **Grassley**. I agree with you, we have to do much more; but you say they will save some, in and of themselves, as opposed to them being a necessary pressure point which leads to cost sharing, which in turn will bring about the political pressure?

Dr. **Sloan**. Right. They will save both directly, and hopefully indirectly, through the pressure that they put on private sector, where most health care expenditures are. Medicaid is just a little piece.

Senator **Grassley**. My last question is a little more encompassing, and I would like to have each of you respond to it.

About the general subject of whether or not from your study of the various States that have cost-control measures; how they might impact upon rural areas and rural hospitals? A State like my State, Iowa, can learn from that, whether or not there is any particular problems. I am looking at a map of Iowa which shows per capita inpatient costs that vary from our major metropolitan area of $340, to our rural area that would be at least a moderate- to high-income rural area, at least in wealth of $367 per capita inpatient cost. It even varies among urban areas, like from the $340, the second largest urban area would be $248, the third largest urban would be $223.

So even among urban areas we have vast differences, and we have vast differences within rural areas. Another rural area, relatively poor part of the State, $344 per capita inpatient cost.

So thinking of Iowa as a State where 40 percent of the people live in the 10 most populous counties out of 99 counties, what sort of recommendations, or what can we learn from your studies of State control cost measures in regard to rural areas and rural hospitals?

You can start here and go that way if you would please.

Dr. **Schramm**. Thank you, Senator.

In Maryland, we often think of ourselves in the phrase "America in miniature." As a regulator and vice chairman of the commission, I have dealt with problems of rural hospitals. We have very rural parts of Maryland. As you know, the Eastern Shore is a particularly remote area in need of care. We have hospitals on the Eastern Shore which have a medicaid population percentage that rivals inner-city Baltimore. There is an awful lot of poverty in rural Maryland.

I think, however, that the answer to your question is that the focus of regulation has to be on the inner city and the high-cost hospitals, the ones where the cost to the State is in the hundreds of thousands of dollars. The regulatory focus, in large part, does not come to the rural hospital. Indeed, in our State, I think the rural hospitals are already insulated, because for most of them there has not been such a critical problem in terms of inflation in the cost of care in those institutions.

Dr. **Morone**. I think if the DRG's and the new medicare regulations put a squeeze on medicare payments, and hospitals begin to shift costs to the other payers, we will develop the same kind of balloon that I was describing in New Jersey. I think any area or hospital that is particularly reliant on public funds, on medicare and medicaid, to finance medical systems is going to have problems. They are going to get caught with the wrong mix of patients, caught in the squeezing of the balloon.

I think that this will tend to be true of rural areas which, as I understand it, rely quite heavily on medicare. So what I was describing for the inner-city hospitals in New Jersey, may be very much like what you will get in rural areas.

Mr. **Crosier**. We are going to see some evidence in the situation you would expect, where the leaner rural hospitals with less surplus in their budgets feel the pinch the hardest. And all I would say is, what we have tried to do is build in relief valves through administrative review, any hardship that could take account of the first wave of that, I think we have to wait for a second and third year of implementation to really see what this proportion squeeze does look like.

It is not equitable where you have large amounts of medicare and medicaid patients. Trying to participate and build it in any State legislation up front I think would be almost impossible.

Dr. **Sloan**. I have three brief responses. The first is that rural hospitals in many States seem to be in some trouble. The rate of acquisition by chains of the small, freestanding hospital is really tremendous. And this is true in States without any ratesetting. And there may be a capital crisis. It is hard for smaller, freestanding hospitals to attract funds. This is a problem, and this is a problem for rural areas.

As for DRG's, it is much harder to predict because it depends on how the DRG pays rural hospitals. There is a separate payment schedule for rural hospitals. The country is divided into 18 regions, and some hospitals in the rural areas are not going to do that badly under DRG percent because the payment is relatively good for them. Some other hospitals may be hurt.

Third, the effect under State ratesetting depends so much on how the States set up the program. States may exempt these hospitals. The States could develop a separate formula for these hospitals.

If a State goes to budget review, it can be flexible in the rates that are established for these hospitals. It is hard to generalize. If the States are sensitive, rate saving should be able to accommodate differences in costs beyond the individual hospital's control.

Chairman **Heinz**. Senator Grassley, thank you.

Senator Bradley.

Senator **Bradley**. Thank you very much, Mr. Chairman.

Let me ask Dr. Morone: In the New Jersey experience, has the quality of health care changed?

Dr. **Morone**. They always say it is too early to tell, and we need more studies. There are great hopes that, in fact, quality will be improved. The people who designed the system really had an idea that they were going to start trying to improve the quality of medicine and not just go around slashing costs.

One thing often overlooked is that DRG's do two different things. They set prices, but they also take what the hospitals can do to patients and break it into a manageable number of categories. This, in itself, is a very useful innovation. Prices can then be set, not arbitrarily, but on the basis of what physicians have done, and hospitals have done, in the previous years.

So, it is an effort to capture the norms of the medical profession and punish lavish use of resources. In that sense, I think it can actually improve quality.

Senator **Bradley**. If it is still too early to tell, what three things are you looking for to be able to assess whether quality has improved? And how should we respond to the perception among some constituents that their relative was let out of the hospital too early, and they blame it on the DRG system as opposed to any of the other 100 factors that might have gone into that position?

Dr. **Morone**. I think you are right to imply that one important thing to watch is the response of the public and see how they perceive their hospital system is treating them. It will be interesting to watch the data, over time, on how New Jersey is doing in terms of treating its ill people.

Senator **Bradley**. What criteria would you look for to determine that quality has improved?

Dr. **Morone**. If I could just add one more point: Insofar as New Jersey is finally getting services to the inner city in a way it has not done before, it will have an enormous impact on quality. All the reports suggest that this is precisely what is happening. I think that is an important thing to keep in mind, extremely important to keep in mind.

And I guess I take very seriously just what the public opinion polls seem to indicate. But quality is a difficult thing to get a handle on, it is very difficult.

Senator **Bradley**. That is why I am asking you.

Dr. **Morone**. I wish I had a good answer for that.

Senator **Bradley**. Would anyone else like to take a crack at what criteria would you look for that shows whether quality will improve under the DRG system?

Chairman **Heinz**. Everybody favored voluntary efforts, but not voluntary criteria?

Senator **Bradley**. There is no way we can measure?

Dr. **Schramm**. Senator, I will have a crack at that.

We have had tremendous problems as policymakers dealing with the question of quality. Quality is questioned at every turn.

At this point there is very little in all of medical science which attempts an empirical measure of quality. As a lawyer, it seems logical to shift the burden and ask those who allege that quality has deteriorated. However, to present evidence from a political perspective obviously that is an inadequate answer.

One of the first things that Professor Morone pointed out, is that quality will have been improved if, in fact, we can insure access to poor people whose health is generally imperiled.

I think that as we move further into a debate of the question of quality, it is appropriate to ask questions concerning mortality or morbidity, and we might ask the Federal Government to anticipate funding studies in this area from time to time. Perhaps these questions should be asked on an institution by institution basis, thus allowing people to make a doctor or hospital decision accordingly.

Senator **Grassley**. Let me ask one more question, and it can go down the row.

One of the fears that has been expressed to me is that here we have set up all these categories for payment, and one of the measures that we have is whether the quality is there, whether the poor people are being served. There are more services, therefore, the program seems to be working. Then we get a situation where, over a period of time, these diagnostic-related categories go up in price, as they will, average cost up over time, and yet we in the Congress do not spend the necessary funds for medicaid or medicare.

Does this lead to a two-tier health care system defeating the original purpose, which is controlling cost?

Does it also frustrate what you have said is one of the measurements of quality, which is delivering health care service to people, poor people in cities and rural areas?

Dr. **Sloan**. There is a problem within the DRG, there is inevitably going to be a substantial variation in patient health within DRG. For example, say a hospital gets $4,000 for each DRG 232 case under medicare for medicare patients. Suppose this patient costs the hospital $9,000 to treat. With efficient measures, it can cut the cost down by $2,000, but this leaves a per case expense of $7,000 versus a payment of $4,000. So what can the hospital do next?

Well, one thing it can do next is to try to get rid of this unprofitable patient. The question is this: As the DRG system gets more binding, what is going to happen to those patients? It raises two additional questions.

First, will some patients be denied access? For hospitals that get these patients, how are they going to survive?

You are not going to see this in the short term, but it is a definite danger for the long term.

Senator **Bradley**. Long term is when?

Dr. **Sloan**. 1986-plus, when the program is fully implemented.

Mr. **Crosier**. Mr. Chairman, Massachusetts is a DRG-waivered State at the moment. But I would make an observation as the result of some conversations with physicians, they will allege—and I think rightly so—that they are not going to compromise on quality because of price, they are going to deliver what their professional pledge says they deliver, quality care.

The greatest concern, I think, is not quality but access. I think the access will be more restricted as cost restraints are applied across the country. That is going to be a very difficult political fact of life. If you want a system that costs less, it has to be smaller, all of which means unemployment in the health care delivery system, while making sure that people, who maybe before could walk across the street to a hospital, now are going to take a 10-minute bus ride.

I think that the major attention is going to have to be devoted to an issue that has not been discussed here this morning, and is in large part a question of who is going to pay for medical education and experience, as the graduates of medical schools go into their internships in hospitals. That is something which is a very large fiscal responsibility on teaching hospitals, that has not been addressed at all.

Senator BRADLEY. What about what Mr. Sloan said?

Mr. CROSIER. That happens today, Senator, where medicaid patients are dumped into particular hospital settings. In the State of Massachusetts, one hospital takes care of one-quarter of the indigent population.

Senator BRADLEY. Are you saying the DRG has no effect on that?

Mr. CROSIER. I do not think I am qualified to say the DRG system itself. I say any system where the Government does not pay its equitable share of the costs.

Senator BRADLEY. That is the point then?

Mr. CROSIER. Yes, sir.

Dr. MORONE. I agree with Mr. Crosier. Controlling just some costs does definitely set up a two-tier system. Hospitals that cannot shift their costs are in trouble. It seems to me, if you set up a DRG system, as New Jersey did, and include in the DRG prices the cost of treating people who cannot pay, then you begin to vitiate the two-tier system. But unless you do that, you will get one.

Dr. SCHRAMM. The current system definitely induces hospitals to behave in a manner that discriminates against patients whose payer will not pay the full cost of care, medicare and medicaid patients. One of the benefits of designing a State system for all payers is that you can develop an insurance pool in which the same price is paid for every single patient. This would insulate the patient at the hospital door from scrutiny, as to whether or not the patient is going to be paid for by a full-cost payer, or by the Federal Government.

Senator BRADLEY. Yes or no. Should we have an all-payer system?

Dr. SCHRAMM. Yes.

Dr. MORONE. Yes, sir.

Mr. CROSIER. Yes, sir.

Dr. SLOAN. No, no, sir.

Chairman HEINZ. Gentlemen, thank you very much. You have been very helpful.

Unfortunately, a number of us, Senator Grassley, Senator Bradley, and myself, have a Finance Committee meeting that started 10 minutes ago.

Senator Percy is going to return in a few minutes to continue the hearing. But in fairness to him, and his generous willingness to continue to chair the hearing, we are going to have to dispense with any further questions for you. But you have all been extremely helpful, and we find your testimony challenging indeed.

Thank you very much.

Our next panel consists of Lynn Etheredge, scholar-in-residence, Center for Health Policy Studies, Georgetown University, Washington, D.C.; Leona Butler, director, provider contracting and public affairs, Blue Cross of California, Oakland, Calif.; Jack Cook, president, Health Systems Research, Inc., Boston, Mass.; and Leonard Schaeffer, president, Group Health, Inc., Minneapolis, Minn.

[Short recess.]

Senator PERCY [presiding]. Mr. Etheredge, you are the scholar-in-residence at the Center for Health Policy Studies at Georgetown University. Since you are conveniently located, would you please be our first witness?

STATEMENT OF LYNN ETHEREDGE, SCHOLAR-IN-RESIDENCE, CENTER FOR HEALTH POLICY STUDIES, GEORGETOWN UNIVERSITY, WASHINGTON, D.C.

Mr. ETHEREDGE. Thank you, Mr. Chairman.

The medicare program faces bankruptcy by the end of this decade, and Department of Health and Human Services estimates a cumulative deficit of more than $1 trillion over the next 20 years.

Basically, there are three ways to deal with this problem. First, we can restrain growth of health care costs and have a more efficient and less inflationary health care system. If we do not contain health costs, the two other choices are to shift cost burdens to the aged and disabled, or go to the taxpayers and ask them to pay a lot more.

I think this committee, and most other people that I have talked to, believe the Federal Government ought to start by dealing with the runaway costs of the health care system, and, only after making these savings, look to the aged, disabled, and taxpayers. If Congress just shifts costs to the aged, and does nothing more about health care costs, the aged would have a benefit reduction of about 30 percent of medicare costs, amounting to $1,500 to $2,000 added out-of-pocket expenses in the 1990's, just for their health care.

What can be done to foster a more competitive and efficient health care system? Clearly, there are a lot of factors which make it look like there already should be a very competitive health care system: Physician supply rose 40 percent in the last 10 years, and is going up another 30 percent in the next 10 years. Hospitals have 25 percent excess capacity. HMO's are developing nationwide, and developing networks to compete for national accounts. Yet, real rates of increase in hospital costs are near record rates; and physicians last year, even in the recession, increased their real income at the highest rate in more than a decade.

So the central question is: Can competition slow health costs in the future, when it has not worked in the past?

Some, as Dr. Sloan said this morning, believe that this will just occur as cost pressures continue to build, even more than they have in the last 10 or 15 years. Let me suggest, however, that two major changes are needed to develop a more competitive health system.

One is to change the way in which we pay for health care. And the other is to get more efficient managers and providers of health care, particularly HMO's.

Let us look first at the problems of trying to get a better way of paying for health services. Medicare, after nearly 20 years, has finally shifted to a DRG system of prospective hospital payments. But it still has not addressed the physician payment program, which is going to be $24 billion next year, larger than medicaid, and is growing at over 20 percent a year. It is the largest uncontrolled program in the Federal budget, and the only major one that has not been addressed by the Congress in the last few years.

Physician payment reform links very importantly to the problem of medicare's trillion dollar deficit in the hospital insurance program. Medicare pays surgeons five times as much per hour as physicians who provide services on an outpatient basis, and internists twice as much per hour for things they do in the hospital as for things they do in the office. The result has been increased hospitalization, and HHS projects those trends will continue.

So I would say, as far as the Federal Government is concerned, the next major item on the agenda for containing hospital costs is to address the physician payment program.

In the private sector, you find that almost none of the payers have moved from open-ended payments to DRG's or similar kinds of restraints. The question is: If competition is such a great idea, why has it not been done?

There are two key problems. One is that in health care it is often very hard to know what it is that you are buying in advance, and what you ought to pay for it. The DRG system, for example, took years of computer statistical analysis on the basis of millions of claims. And even physicians have a hard time agreeing about medical care; there are 6:1 variations in elective surgery procedures, 50 percent variation in the length of stay.

The second major problem is that most insurers simply cannot control their costs. There are over 300 health insurance companies. They usually have less than 5 percent of an area health care market, too small a market share to be able to contain costs or negotiate with providers. As a result, what we have seen in the past—and continue to see—is a great deal of cost shifting.

There are three ways to change this situation to promote competition: One is some kind of all-payer cap on maximum notes, to prevent cost shifting. This is essential, in my view. The second thing that might be done to promote competition is partial exemption from antitrust laws for some small insurance companies. And the third is simply do nothing, allowing several hundred of the insurance companies to go out of business, and leaving the field to the HMO's and a few very large insurance companies, that can put together PPO's.

On the problem of developing new systems of care, the Government has tried a great many things in the last 10 years. HMO's have been the most successful, but there are many other ways to manage health services. The Government has also tried PPO's, and networks with community health centers, community hospitals, and teaching hospitals as managers of other providers. The physician groups have also wanted to be the overall managers of services.

The key elements of all these reform ideas, I think, are very clear. One is that new organizations must be developed that manage care; and two, the organizations must include the physicians. We cannot continue to split hospitals and physicians, each paid separately by medicare and other payers, and develop the integrated management systems that are needed to manage resources. And only if we can manage resources well are we going to be able to save money in the long run.

So my conclusions are that there are ways to address medicare's trillion dollar problem by a more efficient health system. But the private sector just does not now have the kind of purchasing structure or organizational structure that is going to allow it to contain costs in the near future. And medicare physician payment reforms are needed. With such changes—and over a period of several decades—we can make a major dent in the medicare problem.

Senator **Percy**. Thank you very much, indeed.

[The prepared statement of Mr. Etheredge follows:]

Prepared Statement of Lynn Etheredge

Mr. Chairman and members of the committee, my name is Lynn Etheredge with Georgetown University's Center for Health Policy Studies. Previously I served more than 10 years with the Office of Management and Budget, from 1978 to 1982, as chief of its health staff.

Despite its new hospital prospective payment system, the medicare hospital insurance trust fund is now forecast to be bankrupt by the end of this decade. Unlike social security, which had a temporary financial insufficiency, the medicare trust fund's deficits will rise rapidly. The HHS actuarial report projects a deficit of $144 billion by 1995, $452 billion by 2000, and over $1 trillion by 2005.

There are three basic approaches to solving medicare's financial problems. First, the projected rapid increases in medicare payments to providers can be slowed, the health system made more efficient and less inflationary. Even with prospective hospital payments, the HI trust fund outlays are projected to grow more than eight times, from $40 billion last year, to over $320 billion by 2005. The uncontrolled SMI program is likely to rise even faster, from $18 billion last year to over $290 billion by 2005. Savings from this program could be used to assist the HI fund.

If the Government is unable to achieve a more efficient health care system, then either the aged and disabled will have to pay for the rising health bills, or taxes will have to be increased. If costs are shifted to the aged, a 30-percent benefit reduction will be necessary, adding $1,500 to $2,000 per year to each beneficiary's out-of-pocket medical bills in the 1990's.

Most people would agree, I believe, that we should look first to economies in the health care system and, only after achieving as many savings as possible in that way, should we ask either the aged and disabled or taxpayers to pay more for medicare benefits.

DEVELOPING A MORE EFFICIENT HEALTH SYSTEM

The underlying economic conditions in the health sector suggest that major potential savings could be achieved from greater competition and more efficient markets. Hospital occupancy rates, for example, average only about 75 percent. When business industrial capacity utilization has fallen to those levels, price competition has slowed inflation; in the health sector, however, hospitals are enjoying some of the highest rates of real revenue increase on record. Similarly, the Nation's physician supply rose more than 40 percent in the past decade and oversupplies are already evident in major metropolitan areas. Most of this increase was subsidized by the taxpayers, partly with the expectation that rising physician supply would slow health cost inflation. Yet, last year—and despite the recession—physicians increased their average net income per capita after inflation at the highest rate in a decade.

Nevertheless, many changes over the past decade indicate that the health sector is responsive to economic considerations. More than 30 percent of hospitals are now members of multihospital systems, and the for-profit hospitals are a major force, particularly in the Sun Belt States. More than half of physicians now participate in some form of group arrangement and increasing numbers are incorporating. And the HMO industry is now represented in all major metropolitan areas and is forming networks to compete for national accounts.

A major challenge for health policy is to analyze why the health sector has been able to avoid the vigorous competition which could have slowed inflation already—and then to see how such market forces might be strengthened in the future to slow health cost rises, for medicare and other payers.

PURCHASING HEALTH SERVICES

The basic elements of an efficient, competitive market are the same, in health care or elsewhere. First, one needs effective, cost-conscious purchasing arrangements for health services. Second, there must be provider organizations which can manage resources efficiently, not just shift costs or deny necessary care. A review of the health financing and delivery system from this perspective can provide a sense of what is still needed to develop a more efficient and less inflationary health sector.

The dominant method of paying for health care has not been cost-conscious purchasing of services—it has been open-ended third-party (government and private insurance) reimbursement. Hospitals have been paid whatever they spent (by medicare, medicaid, and some Blue Cross plans) or charged (by commercial insurance and most Blue Cross plans). With the advent of medicare, third-party physician payments also shifted from fee schedules toward UCR-type reimbursement methods, so physicians are now also usually paid on the basis of what they decide to bill.

The Federal Government has recently shifted medicare from open-ended hospital cost-reimbursement to a prospective payment system—which is a major improvement—and is allowing States to adopt new medicaid hospital payment methods. Yet medicare physician payments are still open ended—and highly skewed toward running up higher hospital bills. Even after adjusting for complexity, for example, medicare pays five times as much per hour for surgical procedures as for office-based care. And nonsurgical specialists, such as internists, receive twice as much revenue per hour from inpatient services as from office practice. Such factors probably contributed to medicare's 25 percent hospital admission rate increase over the past decade. With physicians controlling most hospital decisions, such as admissions, tests and procedures, lengths of stay, new methods for purchasing inpatient physician services, by medicare and other payers, are critical elements for a more effective hospital cost-control strategy.

Most private sector payers have not moved from reimbursement toward purchasing of health care. The factors involved suggest why there hasn't been more competition in health care.

First, in health care it is often difficult to determine in advance exactly what one is purchasing and what it should cost. Developing the medicare DRG system, for example, required years of computerized statistical analysis of selected data from millions of patients—on approach of more limited usefulness for payers with much smaller market shares. And, on a case-by-case basis, even physicians have great difficulty in agreeing on appropriate medical care, as evidenced by 6:1 regional variations in elective surgery rates, 50 percent regional variations in lengths of stay, and the limited effectiveness of the PSRO program.

Second, with the exception of Blue Cross in a few areas, the more than 300 health insurance companies individually usually have less than 5 percent of area health care markets. As well, their payment commitments are usually with beneficiaries, not with providers. As a result, insurance companies have very little ability to protect themselves against hospital cost shifting.

The importance of hospitals' ability to shift costs and avoid competition is brought out in a recent study by Catherine McLaughlin with Jeffrey Merrill and Andrew Freed at the Georgetown Center for Health Policy Studies. Under a grant from the Robert Wood Johnson Foundation, the hospital cost experience of 25 areas was analyzed over a 10-year period from 1971 to 1981, in a cross-sectional time series analysis, to determine the impact from rapid growth of HMO's. This was the most exhaustive study to date of the effects of HMO competition on the health care market. The study's conclusions are that, although HMO's save money for their enrollees, their net effect has been to increase total health spending. At the average 6 percent HMO market penetration rate in the study, for example, overall costs were increased by 4 percent. The most likely explanation for these results is that hospitals were able to make up much of their income loss from HMO competition through cost shifting to other payers.

In summary, replacing open-ended reimbursement of hospitals and physicians with purchasing of health care would be the single most important step in creating a more competitive health system. Limitations of data and utilization review can be addressed, but the most important barrier to competition is that many payers are unable to protect themselves against provider cost shifting. As shown by the HMO experience, limits on such cost shifting, via restraints on maximum charges and "dumping" of nonpay patients, appear necessary to realize savings from competition.

BETTER MANAGEMENT OF HEALTH RESOURCES

For much of the past decade, government, and many in the health sector, have recognized that major organizational changes are needed if health resources are to be managed more efficiently. As a result, a number of different models for managed systems of care have been and are being tried.

The most widely tested management model has been HMO's, usually started around a core of an existing insurance plan, hospital, or clinic. The regional medical program attempted to build systems of care around major medical centers, an approach being carried on by NIH clinical centers grants. Community hospitals are participating in demonstrations as overall managers for an area's inpatient and outpatient care, as are neighborhood health centers. Physicians have stepped forward to claim this management role as groups (IPA's) and as individual practitioners (capitation). Some businesses have decided to try health care management, through self-insurance or company HMO's. Economists, of course, have argued for the individual becoming the manager of his own health services by replacing group insurance with vouchers. And the list can be extended—at one time or another, nearly every major actor in the health system has been advocated as the best overall manager of health resources.

The Government's experience with these efforts over the past decade suggests several lessons:

First, in a $350-billion industry, efficient management of health resources and services is much easier to talk about than it is to accomplish. Realistic expectations for systemwide changes should be framed in terms of decades, as evidenced by the growth of the HMO industry.

Second, there is no single "best" model for how to organize and manage local health systems. However, tighter management structures, like group practice HMO's, seem to do the best job of cost control. Also many different financial and organizational arrangements can coexist. A teaching hospital, for example, can operate its own group practice, provide contractual backup service to community health centers and hospitals, be part of a PPO and offer discounts to HMO's, have a competitive bid agreement with the State medicaid program and receive medicare DRG payments.

Third, the single most important requirement for improving management of health resources is an organization that includes both hospital and physician services. This is the single common element of virtually every reform theory and demonstration. In this regard, it is no surprise that HMO's have been able to achieve their major savings by serving patients on an ambulatory basis rather than in a hospital. An important implication is that the fragmentation of medicare (and other insurance) into separate hospital and physician payments works against attempts to improve the integration and management of health services. A combined part A/part B payment system thus should be on medicare's reform agenda.

If we can learn from studies of other industries. the health sector has only just started its evolution from being a fragmented collection of independent actors toward integrated and managed systems of care. Such developments are essential, for efficient management of resources is the core of any real cost savings. These changes can be fostered by preventing cost shifting and emphasizing integrated payment systems, such as capitation vouchers and combined hospital/physician payments for inpatient services.

IMPLICATIONS FOR MEDICARE

While there are major opportunities for developing a more efficient and competitive health system—through better purchasing and improved management of resources—the critical questions for this committee are whether such changes will be enacted and, if tried, how far they would go toward solving the medicare financing problem. There are major uncertainties involved in answering such questions, but let me suggest two major points for your consideration.

One observation is that, unless further actions are taken, it is unlikely that medicare's $1 trillion problem can be handled without major new taxes or cost shifts to beneficiaries:

First, there are still too many opportunities for hospitals cost shifting, which will prevent sector hospital costs from even matching medicare's prospective rates. The major worry of the private sector, ought to be that their health costs will accelerate and that medicare's $1 trillion problem will get shifted over to their health insurance premiums and to their bottom lines.

Second, even with the most optimistic growth projections, medicare enrollments in organized systems of care simply will not be able to produce enough savings. Since medicare enrollees already have established relations with physicians, they have enrolled in HMO's in far smaller numbers (about 5 percent) than the under-65 population. As well, medicare now pays HMO's 95 percent of its average cost for each enrollee. So even if all medicare enrollees joined HMO's, PPO's or other organizations with equivalent economies, the savings would be only 5 percent of program costs--far less than even 1 year's inflation. More realistically, should 20 percent of medicare enrollees join such entities, program savings would be about 1 percent (5 percent of 20 percent).

A final observation, however, is that relatively small changes toward a competitive market—if consistently pursued over several decades—can have major cumulative effects. If the sum of further changes reduced the growth rate of medicare's hospital expenses over 1985–2005 by even 1 percent per year from the HHS projections (8.6 versus 9.6 percent), for example, the HI trust fund deficit would be reduced by about $400 billion. Similarly, holding medicare's inpatient physician payments to the same rate of increase (8.6 versus 13 percent) would produce about $350 billion in net savings by 2005. Of course, the risks on the up side from failing to control costs are equally great.

SUMMARY

In summary, Mr. Chairman, there are major opportunities for developing a more efficient health system and a number of actions which could be taken toward those ends. If we do take such actions—particularly preventing cost shifting and reforming physician payments for inpatient services—then substantial further progress should be possible in reducing medicare's deficits.

Senator **Percy**. Leona Butler is next.

STATEMENT OF LEONA M. BUTLER, OAKLAND, CALIF., DIRECTOR, PROVIDER CONTRACTING AND PUBLIC AFFAIRS, BLUE CROSS OF CALIFORNIA

Ms. **Butler**. Mr. Chairman, I am responsible for putting together a network of providers, or preferred provider organizations, for Blue Cross of California. California, as it often is, is different, is doing something different.

We have a totally new environment in California today, an environment which, in fact, is competition, competition of the type that we have been hearing this morning, competition which has not yet occurred in other places.

It occurred in California for several reasons, and it occurred very fast, almost overnight. Three things happened last year:

On the State legislative side, the State legislature enacted a bill allowing the State to selectively contract for our medicaid population, Medi-Cal in California. And then to restrict access to the hospitals selectively contracting.

Second, the legislation then had a companion measure offered, to offer insurance companies and Blue Cross the ability to also selectively contract, but this time with physicians, as well as with hospitals, and as a result of negotiations with them, to have a reduced premium offered to recipients who would use those contracting providers.

Third, and very significantly, as a part of it, the implementation of diagnosis related groups, or DRG's. Those three combined together to affect a totally new environment.

First, in California today, the cost-based reimbursement is all but dead.

Second—and this has been mentioned today in testimony—physicians and hospitals are having to work together, really for the first time, to achieve the kinds of efficiencies that are necessary in the DRG-type of reimbursement for medicare, and in the per diem kind of reimbursement that the State medicaid program and most private payers are going to in selective contracts.

California has the pressures that have been talked about already. Forty percent of the hospital beds in California are empty. We have an oversupply of physicians, that in most areas of the State far exceed the estimated 10-percent surplus that exists nationwide.

And in listening to the Senator from Iowa speaking about hospital costs there, let me tell you, hospital charges to Blue Cross patients last year were $755 a day. We are now paying more than $800 a day for hospital care in California.

Now, I used to work for the State legislature, and every year, when some kind of regulatory approach was tried, the powerful hospital and physician lobby was able to stop it. And as long as nobody was really paying the hospital bill, that is, no one was really responsible for the bill, no one was very upset about this in California.

Last year, however, a unique coalition formed. Business, labor, senior citizens, consumer advocates, and the insurance industry, including Blue Cross, for the first time came together and developed a unique, unified position that said, "We have got to do something." That something became what, in effect, was a restructuring of the incentives in the health care system.

Blue Cross of California is not so large as in other States. We have a comparatively small share of the market in California. But Blue Cross took the lead, and was out there first, with what we are calling the prudent buyer plan, a preferred provider kind of option. We are first. Many commercial carriers are following.

Let me tell you some other results we are seeing. We have negotiated hospital cost reductions of 23 percent less than what we are paying today. Second, physicians are agreeing to a fee schedule which will be for a year, and will be payment in full.

Third, physicians and hospitals are agreeing to utilization review, the key element.

Now, those three factors are combining together to enable us to offer premiums for this kind of a plan at somewhere between 10 and 15 percent, most about 13 percent, less than comparable benefits.

Now, we are doing that today. We have members on the plan, although we have just started to market 12 large employers have already purchased the plan, with a total membership of about 50,000 employees.

Now, I will say that for the small commercial carriers, in fact, small can be a competitive advantage. Because where a hospital gets very nervous, we represent some large portion of their total patient revenue, they can afford—and have, in fact, done so with a smaller carrier, or in fact with other providers forgetting the insurance company, to offer a considerable reduction in per diem.

Additionally, I simply want to point out that we are trying the same approach for medicare, in a demonstration pilot that we are engaged in in Santa Barbara, where the medicare recipients will have the option of fee-for-service coverage, or HMO coverage, or PPO coverage as their form of insurance.

Now, that gets to the most important issue, which has not been raised today, and that is the issue of choice. The response to many of the problems that exist in terms of cost shift and quality really is, I believe, in the area of offering a choice.

We believe strongly that people must continue to have a choice, and that means medicare, medicaid, and private recipients—choice—at least between an HMO and some other kind of alternative system. And for the private employer, a choice of fee for service, as well.

But let that different cost, let the person be responsible for paying additional cost, when it exists.

Finally, I would urge, from California, give us a year, watch what happens, watch it closely. It is too early for results, but it is very interesting out there.

Senator PERCY. Thank you very much, indeed.

[The prepared statement of Ms. Butler follows:]

PREPARED STATEMENT OF LEONA BUTLER

Mr. Chairman and members of the committee, my name is Leona Butler. I am director of public affairs and provider contracting for Blue Cross of California. It is an honor to have the opportunity to summarize for you some of the extraordinary events that are taking place in health care delivery and financing today in California.

The health care environment has changed dramatically in my State in the last year as a result of three major legislative actions which, combined, have created a truly competitive response in the health care marketplace.

First, the State legislature enacted Assembly bill (A.B.) 799, which enables the State to selectively contract with hospitals for delivery of acute care to our medicaid recipients.

Second, as a companion measure, the State legislature enacted A.B. 3480, enabling commercial insurance companies and Blue Cross to also selectively contract—with physicians as well as hospitals—for private insurance coverage at reduced rates.

Third, on a national scale, the Federal Government has begun implementation of hospital reimbursement by diagnostic related group, or DRG, for medicare.

Combined, these actions are all but eliminating cost-based reimbursement in hospitals in California. Hospitals and physicians are being forced to work together to achieve the efficiencies necessary under the medicare per case type reimbursement and the per diem, or per day, type reimbursement implemented by Medi-Cal and private payers who selectively contract with these providers.

To understand why these changes have initiated such a revolution, some background on health care delivery in California is necessary:

Last year, hospital charges to Blue Cross patients in California rose 22.9 percent. Physician charges rose 7.5 percent. This was at a time when the overall Consumer Price Index increased by 3.2 percent.

Since 1975, hospital occupancy has remained almost constant, with the 1983 average occupancy rate for licensed beds at 59.9 percent. Thus, over 40 percent of the hospital beds in California today are empty.

We also have a surplus of physicians—214 physicians per 100,000 population when need is estimated to be only 182 per 100,000 population. In San Francisco, one of our highest cost areas, we have 504 physicians per 100,000 population.

So we have—too many beds—too many physicians—and $755 paid per patient per day in California hospitals in the second quarter of 1983. Clearly, in health care delivery in California, oversupply results in increased rather than decreased cost.

Efforts of California legislators to enact regulatory cost-containment legislation have been totally unsuccessful. With the powerful physician/hospital lobby, most such attempts have not survived the first committee hearing. And no one worried very much as long as every segment of the economy could pass on the cost of the health care bill to someone else.

Last year, however, a new course was pursued in California. A major reason for the success of the new strategy was the formation of a unique coalition. For the first time, the California business, community, labor, senior citizens, consumer advocates, and the insurance industry joined together in a unified position insisting that something be done about health care costs. For California, "that something" would turn out to be a restructuring of the system in such a way as to introduce competitive forces into an overbedded, overdoctored environment.

The change in law governing private insurance was not complicated. It simply allowed insurance companies and Blue Cross to selectively contract with health care providers for predetermined rates and then to offer incentives to the public to use one of these contracting providers. Almost immediately, a new acronym, PPO, or preferred provider organization, became part of our health care vocabulary.

As the largest carrier of health care coverage in the State, Blue Cross felt it had both the responsibility and competitive advantage to take a leadership role in development of this new health care alternative. Therefore, we were first in the State to implement, on a large scale, a program responsive to last year's legislation.

This program, which we are calling the "prudent buyer plan," is available today in the major market areas of our State. We are just now beginning to market the plan but already have members enrolled—12 large employee groups have purchased the plan. Premiums are from 10 to 15 percent lower than comparable benefits under standard insurance coverage. The average premium reduction is approximately 13 percent.

Two major principles are involved in design of the prudent buyer plan and similar preferred provider concepts:

First, we have selectively contracted with hospitals and physicians. That is, Blue Cross estimated the need for hospital and physician services for our projected membership in the plan. The need was based on number of beds and physicians, scope of services, and geographic access. We then contracted only to the extent necessary to meet that estimated need. We started by offering all hospitals in a geographic area the opportunity to make a proposal to us. We then evaluated the proposals in terms of the per diem price being offered, services, access, quality, and similar factors. After selection of the hospitals, physicians on the staff of a participating hospital were then invited to contract as well.

Second, benefits were designed in such a way as to provide financial incentives for members of the plan to use a contracting, or participating, provider. Unlike the health maintenance organization, or HMO, members of the prudent buyer plan have benefit coverage even if care is obtained outside the contracting network. However, if a member does seek care outside of the contracting network, Blue Cross provides at least 20 percent less reimbursement than if the member received care from a participating provider.

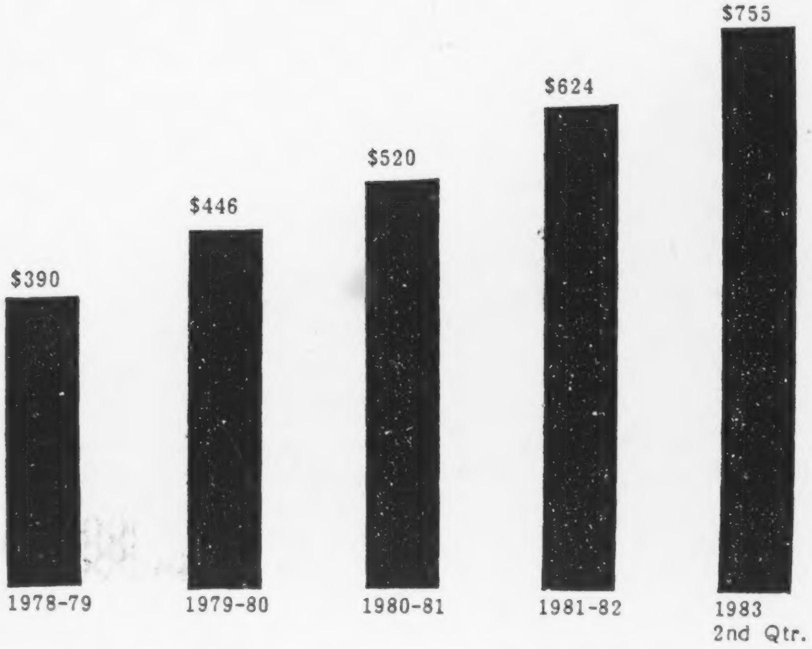
To understand why such a concept works, it is necessary to keep in mind we have an overabundance of physicians and hospital beds in our State. The extent to which Blue Cross has been able to obtain an advantageous rate from an acute care hospital is dependent on the extent to which the hospital can anticipate additional patients to fill its empty beds.

To date, Blue Cross has contracted in the major population areas of our State and has developed a network of 114 participating hospitals and 6,500 participating physicians. Our hospital negotiations have resulted in an overall 23 percent reduction in what we will be paying hospitals for the prudent buyer plan as opposed to their usual charges. To give you some idea of the new competitive spirit being demonstrated by hospitals today, of the 450 hospitals we have approached for this plan, only 43 have chosen not to make a proposal.

Although Blue Cross of California entered the marketplace first, a number of commercial carriers are also at some phase of implementation of a similar plan. Obviously, it is far too early to evaluate the results of this approach to controlling health care costs. I urge, however, that you watch very closely what happens in California—we believe it is going to work. And clearly, labor and employers believe so too. With DRG's for medicare, selective contracting for medicaid, and the private sector now in place, we need the time for competition to demonstrate results. Watch us, compare us with the all-payer States, and then, based on such evaluation, make your decision.

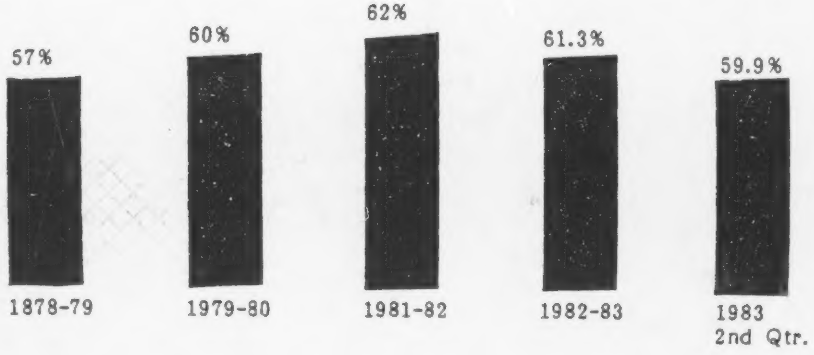
Thank you.

HOSPITAL CHARGES PER PATIENT DAY IN CALIFORNIA



SOURCE: CALIFORNIA HEALTH FACILITIES COMMISSION

HOSPITAL OCCUPANCY RATES IN CALIFORNIA



SOURCE: CALIFORNIA HEALTH FACILITIES COMMISSION

BEST COPY AVAILABLE

INCREASED HOSPITAL CHARGES TO BLUE CROSS

1981 to 1982 = 22.9%

INCREASED PHYSICIAN CHARGES TO BLUE CROSS

1981 to 1982 = 7.5%

CALIFORNIA/NATIONWIDE COMPARISON

Ratio of Physicians per 100,000 Population

	1977	1979
Nationwide	185	194
California	208	214

SOURCE: CALIFORNIA HEALTH MANPOWER PLAN
OFFICE OF STATEWIDE PLANNING AND DEVELOPMENT

OVERSUPPLY OF PHYSICIANS

Los Angeles/San Francisco Areas

Physicians per 100,000 Population

	Recommended Standards*	Actual**
Los Angeles	182	218
San Francisco Area	182	504

SOURCE: * CALIFORNIA HEALTH MANPOWER PLAN
OFFICE OF STATEWIDE PLANNING AND DEVELOPMENT

** BOARD OF MEDICAL QUALITY ASSURANCE SURVEY
(range median)

OVERSUPPLY OF PHYSICIANS IN CALIFORNIA

Population Increase (1966-1979)	21.4%
No. of Physicians Increase (1966-1979)	49.9%

SOURCE: CALIFORNIA HEALTH MANPOWER PLAN
OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

BEST COPY AVAILABLE

Senator **Percy**. Dr. Cook.

STATEMENT OF JACK COOK, PH. D., PRESIDENT, HEALTH SYSTEMS RESEARCH, INC., BOSTON, MASS.

Dr. **Cook**. Thank you, Senator Percy.

My understanding is that I am to describe the payment system in the Rochester area of New York. I will attempt to do that in the next 5 minutes.

The system is called the hospital experimental payment demonstration, and it is one of the six medicare waiver systems in the United States. There are four State medicare waiver systems and two regional systems. One regional system is in the Rochester area, and one in the immediate region next to it, which is called the Finger Lakes area.

The hospital experimental payment demonstration was developed by the Rochester Area Hospital Corp. The Rochester Area Hospital Corp. is composed of trustees of the nine Rochester area hospitals, supplemented by two trustees from the University of Rochester School of Medicine and Dentistry.

It began in January 1980, and to a very large extent was an extension of ideas which were developed initially in Maryland. But it had the advantage of being a contract. And because it was a contract, it could amend some of the difficulties in the Maryland legislation.

As I mentioned, the hospital experimental payment demonstration is a full-payer system. So in particular, medicare, medicaid, and Blue Cross all pay on the same terms. And it enjoys both a medicare and a medicaid waiver. It is a prospective system in that the amounts of payments derived in any particular year are derived from the preceding year's payments without reference to actual costs. So in that respect, it is like the five other medicare waiver systems.

The key feature of the Rochester system, which is different from any other system I have ever heard of, and I believe any other system that has ever been tried, is that it establishes a regional budget for the entire hospital industry. The contract, in effect, stipulates that the hospitals in Rochester will receive about $350 million per year, adjusted for inflation, and further stipulates how much of that portion will be paid by medicare, medicaid, Blue Cross, and charge paying patients. The payment demonstration's cost performance from 1979 to 1982 was such as to beat the general rate of inflation in hospital costs by 7 percentage points per year.

If the national experience for medicare, from the payment demonstration's base year, 1978, through 1982, had been equal to that of Rochester, medicare would have saved about 30 percent, and had enough money left over to fund almost the entire Federal share of the medicaid program.

During this time, the hospitals maintained, or improved their financial positions. So on these grounds, the current medicare demonstration in Rochester has easily been the most successful, beating both Maryland and New Jersey by between 3 and 4 percentage points per year in increased costs per capita.

A reasonable question is, what are the reasons for success in Rochester. And I suggest that there are basically three reasons, the first of which are the trustees. The trustees are well informed, and have a relatively unique role, in that they actually set the industry's policies. This is, of course, illustrated by the development of the experiment itself, which was done by the corporation.

Now, I realize that that is not a very exciting point to be making before a Senate committee, but I think it is important to compare what goes on with the Rochester trustees, with what goes on in most hospital board rooms. And in order to do that, I have to open the door of the hospital board room, and have you visualize what goes on there. It is basically a conversation carried on by the well to do of the community in which very little is done in regard to policy, and, in fact, most of the policy is delegated to the hospital's medical staff.

Now, apart from the well-informed trustees, a second reason that the system works as well as it does, is the system's design. The aggregate reimbursement of the industry and the underlying incentives of the contract are clear. The contract is simple, payment is easy to compute, and the contract's policy implications are also easy to understand. And they are to reduce inpatient hospital costs as effectively as possible.

It treats the hospital industry as a system. It does not pay individual hospitals exclusively, but rather directs a substantial proportion of available revenue to a community fund. By not focusing on individual hospitals, it introduces an element in hospital financing which has been missing in the past, and that is the idea that you should treat the industry as a system from a financing point of view, if you want it to act like a system from a medical delivery point of view. Our critics regard the system as neat, rational, and wrong. The history of Rochester is the third element, I think, which is among its reasons for success. It was preceded by a tough State system which was driving the hospitals into insolvency. Rochester has a good Blue Cross plan, its benefit packages are well defined, and Rochester has had the further benefit of a good health planning process. In fact, in some respects, Rochester is the home of health planning.

Rochester, in contrast to California, has an average occupancy of about 90 percent in medical-surgical, so there is, in essence, no excess at all in the Rochester system.

Another question is whether it is reproducible. And my answer to that is, of course it is reproducible.

The main shortcoming of the system, I think, is that it does not have the property that it introduces financial incentives to the physicians, which are consistent with the financial incentives facing the hospitals.

And in this regard, perhaps this is a good introduction to our next speaker, in that the natural direction that I believe the Rochester system go is to managed care delivery in which payment is made for both the physician and the hospital jointly. I am hoping that they will develop such a system as a second generation of this program.

Senator PERCY. Thank you. We appreciate it.

Leonard Schaeffer.

STATEMENT OF LEONARD D. SCHAEFFER, PRESIDENT, GROUP HEALTH, INC., MINNEAPOLIS, MINN.

Mr. SCHAEFFER. Thank you, Mr. Chairman.

I am president of Group Health plan in Minneapolis, Minn. Group Health is a member-governed health maintenance organization. It was founded 26 years ago. Today we have over 200,000 members, and we are the largest HMO in the Midwest.

Prior to joining Group Health, I was involved in the delivery and financing of health care at the Federal, State, and local level. At the State level, I was deputy director of the department of mental health in the State of Illinois, where we run 28 hospitals and over 100 outpatient clinics. I was director of the budget of the State.

At the Federal level, I was Assistant Secretary for Management of the Budget of Health and Human Services, and later Administrator of the Health Care Financing Administration. As a result, I am aware of the complexity of the cost issues and the concern they bring you today.

This committee also knows the impact of the increase of the magnitude that our Government has faced, have had on the growth of the Federal budget, and on the potential insolvency of the medicare program.

The question is what to do about it.

The approach taken in the last few years has been to limit Federal program spending. These limits can control the Government's share of spending, and can limit the system, such as the size of the system, such as medicare.

However, this alone cannot solve the problem. It simply limits benefits and access. The danger—I think it is a real danger—is that this approach will lead to reduced services for the elderly and poor who depend on these programs for their care. To fail to provide these people with the range of interventions that are now immediately available would be inconsistent with our national philosophy.

Federal cost controls alone do not work. The underlying structure of health care in our country—health care in the United States is not delivered in an organized economic system.

We talk about aggregate spending and overall health care costs. But these totals are simply the sum of millions of discrete interactions, interactions that occur largely between physicians and patients. The physician has the medical decision.

More importantly, the financial incentives underlying most of these interactions lead directly to high value, high cost intervention. Inpatient care is favored in view of being much more costly, and often more appropriate than outpatient care.

We should not be surprised when the sum of all these encounters is ever increasing health care billing. There have been no incentives, no rewards for other types of practice patterns.

HMO's are organized systems of care with a set of incentives. These are incentives which focus both on the patient and the provider, and two important things. First, keeping healthy, second, using health care resources wisely. That is why the concept is so unique.

HMO's encourage their members to make the lifestyle changes that will make them well. We educate our members to use our system of care wisely, and they benefit in terms of their premiums. We encourage our physicians to stress prevention.

The result of these efforts is joint support, joint between patient and physicians, for better health and lower costs, and joint rewards when this outcome is achieved.

HMO's that are accountable to their members can control overall costs because we provide incentives for both patients and providers to optimize the health status of all members. Accountability means responsibility for delivering quality health care at a reasonable price.

Our members expect both, and they are able to evaluate both. To achieve both, we must manage a complete health care system. We provide both the financing and delivery of care in an efficient manner.

My experience is, well-managed system of care will be cost effective when revenues are prepaid, and when there is competition present.

The materials attached to my prepared statement highlight the results of our efforts in the Twin Cities area, where there are now six active HMO's serving over 30 percent of the population, and competing like you would not believe. You will note that in 1982 Twin Cities HMO's experienced about 400 hospital days per 1,000 members, while the area average was over 1,000 days per insured. In 1978, the last year when data was available, HMO length of stay was 62 percent of non-HMO use.

Now, medicare reimbursements will soon make HMO's more available. For the first time, HMO medicare members will receive the full benefits of HMO benefits. This brings down out-of-pocket expenditures, no worry about locating providers, no confusing paperwork, and more services for their health care dollars.

The point I wish to make today is that this will happen not as a result of the Federal limit on spending, but as a result of a Federal investment in a health care delivery investment that provides incentives to change behavior.

I personally do not believe that the Government can effectively regulate the new price controls. The only long-term solution is a set of incentives that gives individuals greater responsibility for their own status, and encourages providers to focus on maintaining health first, and intervening only when necessary.

HMO's are not the complete solution. However, we see an indirect impact on the rest of the health care community. HMO's have demonstrated that a prepaid, organized delivery system, offering comprehensive care and cost-effective allocation of resources can be achieved without sacrificing quality.

By providing an alternative to the fee-for-services system, the element of competition in the health care marketplace, which challenges others to match our achievements.

One attractive strategy for promoting health care costs is to assure that HMO's continue to have equitable opportunities to compete.

This committee and Congress will be looking at a variety of approaches to control health care costs. As you consider these approaches, I urge you to protect the incentives that allow HMO's another prepaid, other alternative delivery systems to compete.

For example, as you look at ratesetting, you should understand the limits on hospital costs per admission are counterproductive for HMO's, because they do not recognize what we do best, reduce the length and intensity of a hospital stay.

And I might just note, after the first panel, I was fascinated by the discussions, I think there are some basic misunderstandings about what hospitals are. A key insight perhaps is, you cannot get into a hospital unless a physician admits you, and you cannot get out unless the physician discharges you.

Controlling hospital prices might result in the control on total expenditures on the third-party insured, but the real issue is utilization. Until we make the financing, hospital care, and the activities which physicians control, are not going to get the financial result we want. Seventy-four percent of all costs occurred in hospitals are a result of a doctor's written orders. Doctors are independent of the entire financing mechanism that funds money to hospitals.

And please let me be clear. I am not criticizing physicians. I think the point is, we focus on hospitals because we know how much money is being spent there. But I think we ought to take a look at the whole system, change the system.

Please also consider the other factors that lead to increased costs in our health care system. One such factor is the supply of physicians, the supply of hospital beds. Despite our concern with our costs, I urge you to keep in mind what public programs have done, and continue to do an enormous amount of good. We have a national commitment to continued access to care for the aged and the poor. And this committee——

Senator **Percy**. Mr. Schaeffer, I am going to have to ask you to draw your statement to a conclusion.

Mr. **Schaeffer**. Sure.

I think the point is to find a mechanism to provide care more efficiently. And I think you can do that by building systems of care.

Senator **Percy**. Thank you very much.

[The prepared statement of Mr. Schaeffer follows:]

PREPARED STATEMENT OF LEONARD D. SCHAEFFER

MR. CHAIRMAN, I AM LEONARD SCHAEFFER, PRESIDENT OF GROUP HEALTH PLAN IN MINNEAPOLIS, MINNESOTA. GROUP HEALTH IS A MEMBER GOVERNED HEALTH MAINTENANCE ORGANIZATION THAT WAS FOUNDED 26 YEARS AGO. TODAY, WE HAVE OVER 200,000 MEMBERS, AND ARE THE LARGEST HMO IN THE MIDWEST. I AM VERY PLEASED TO BE HERE TODAY TO TALK ABOUT WHAT HEALTH MAINTENANCE ORGANIZATIONS CAN DO TO HELP CONTAIN HEALTH CARE COSTS.

PRIOR TO JOINING GROUP HEALTH I WAS INVOLVED IN THE DELIVERY AND FINANCING OF HEALTH CARE AT THE STATE AND FEDERAL LEVEL. I SERVED AS DIRECTOR OF THE BUREAU OF THE BUDGET OF THE STATE OF ILLINOIS, ASSISTANT SECRETARY FOR MANAGEMENT AND BUDGET OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION. AS A RESULT, I AM AWARE OF THE COMPLEXITY OF THE COST ISSUES THAT CONCERN YOU TODAY.

THE TRENDS IN OUR NATION'S HEALTH SPENDING CERTAINLY DESERVE YOUR ATTENTION. TOTAL PRIVATE SECTOR SPENDING FOR HEALTH CARE INCREASED THREE TIMES IN THE LAST DECADE. PUBLIC SPENDING INCREASED NEARLY FOUR TIMES, AND FEDERAL SPENDING FOR THE AGED UNDER MEDICARE AND MEDICAID INCREASED FIVE TIMES.

THIS COMMITTEE IS WELL AWARE OF THE IMPACT THAT INCREASES OF THIS MAGNITUDE HAVE HAD ON THE GROWTH OF THE FEDERAL BUDGET, AND ON THE POTENTIAL INSOLVENCY OF THE MEDICARE TRUST FUND.

THE QUESTION IS WHAT TO DO ABOUT IT.

THE APPROACH TAKEN IN THE LAST FEW YEARS HAS BEEN TO LIMIT FEDERAL PROGRAM SPENDING. THOSE LIMITS CAN CONTROL THE GOVERNMENT'S SHARE OF SPENDING, AND CAN LEVERAGE THE SYSTEM BECAUSE OF THE SIZE OF PROGRAMS SUCH AS MEDICARE.

HOWEVER, FEDERAL SPENDING LIMITS ALONE CANNOT SOLVE THE OVERALL PROBLEM. THEY SIMPLY LIMIT BENEFITS AND ACCESS FOR MEDICARE AND MEDICAID BENEFICIARIES. THE DANGER IS THAT THIS

APPROACH WILL LEAD TO REDUCED SERVICES FOR THE ELDERLY AND POOR WHO DEPEND ON THESE PROGRAMS FOR THEIR CARE. TO FAIL TO PROVIDE THESE PEOPLE WITH THE RANGE OF INTERVENTIONS THAT ARE NOW MEDICALLY AVAILABLE WOULD BE INCONSISTENT WITH OUR NATIONAL PHILOSOPHY.

FEDERAL COST CONTROLS ALONE CANNOT WORK BECAUSE THEY DO NOT ADDRESS THE REAL PROBLEM -- THE UNDERLYING STRUCTURE OF HEALTH CARE TODAY. FIRST, HEALTH CARE IS NOT DELIVERED THROUGH AN ORGANIZED ECONOMIC SYSTEM. WE TALK ABOUT AGGREGATE SPENDING AND OVERALL HEALTH CARE COSTS. BUT THOSE TOTALS ARE SIMPLY THE SUM OF MILLIONS OF DISCRETE INTERACTIONS -- INTERACTIONS THAT OCCUR LARGELY BETWEEN PHYSICIANS AND PATIENTS, WITH THE PHYSICIAN AS THE MEDICAL DECISONMAKER.

SECOND, THE FINANCIAL INCENTIVES UNDERLYING MOST OF THOSE INTERACTIONS LEAD TO HIGH VOLUME, HIGH COST, ACUTE INTERVENTIONS -- AND INPATIENT CARE IN LIEU OF LESS COSTLY OUTPATIENT CARE. WE SHOULD NOT BE SURPRISED WHEN THE SUM OF THESE ENCOUNTERS IS AN EVER INCREASING HEALTH CARE BILL. THERE HAVE BEEN NO INCENTIVES -- NO REWARDS -- FOR OTHER TYPES OF PRACTICE PATTERNS.

IN ADDITION, MANY PATIENTS HAVE SOME FORM OF INSURANCE WHICH INSULATES THEM FROM THE TRUE COST OF CARE AND THUS THEY ALSO LACK THE INCENTIVE TO USE HEALTH CARE RESOURCES PRUDENTLY.

HMOS ARE ORGANIZED SYSTEMS OF CARE WITH A SET OF INCENTIVES WHICH FOCUS BOTH THE PATIENT AND THE PROVIDER ON: 1) KEEPING HEALTHY, AND 2) USING HEALTH CARE RESOURCES WISELY. THAT IS WHY THE HMO CONCEPT IS SO APPEALING. WE ENCOURAGE OUR MEMBERS TO MAKE LIFESTYLE CHANGES THAT WILL KEEP THEM WELL. WE EDUCATE OUR MEMBERS TO USE OUR SYSTEM OF CARE WISELY. WE ENCOURAGE OUR PHYSICIANS TO STRESS PREVENTION AND TO INTERVENE EARLY. THE RESULT IS JOINT SUPPORT FOR BETTER HEALTH AND LOWER COST -- AND JOINT REWARDS WHEN THIS OUTCOME IS ACHIEVED.

HMOS THAT ARE ACCOUNTABLE TO THEIR MEMBERS CAN CONTROL COSTS BECAUSE WE PROVIDE INCENTIVES FOR BOTH PATIENTS AND PROVIDERS TO OPTIMIZE THE HEALTH STATUS OF MEMBERS. ACCOUNTABILITY MEANS RESPONSIBILITY FOR DELIVERING QUALITY HEALTH CARE AT A REASONABLE PRICE. OUR MEMBERS EXPECT BOTH. TO ACHIEVE BOTH WE MUST MANAGE A COMPLETE HEALTH CARE SYSTEM (FINANCING AND DELIVERY) IN AN EFFICIENT MANNER. A WELL MANAGED SYSTEM OF CARE WILL BE COST EFFECTIVE WHEN REVENUES ARE PREPAID AND THERE IS COMPETITION PRESENT.

THE MATERIALS ATTACHED HIGHLIGHT THE SUCCESS OF OUR EFFORTS IN THE TWIN CITIES AREA WHERE THERE ARE SIX HMOS SERVING OVER 30% OF THE POPULATION. YOU WILL NOTE THAT IN 1982 TWIN CITIES HMOS EXPERIENCED ABOUT 400 HOSPITAL DAYS PER 1000 MEMBERS WHILE THE AREA AVERAGE WAS OVER 1200 DAYS PER THOUSAND. IN 1978, THE LAST YEAR DATA WAS AVAILABLE, HMO LENGTH OF STAY WAS 62% OF NON-HMO USE WITH EVEN MORE DRAMATIC DIFFERENCES IN SPECIFIC DIAGNOSES.

A NEW MEDICARE REIMBURSEMENT OPTION WILL SOON MAKE HMOS MORE AVAILABLE TO MEDICARE BENEFICIARIES, AND WE EXPECT TO SEE A SIMILAR IMPACT IN UTILIZATION AND COSTS IN THAT POPULATION.

UNDER THE NEW PAYMENT METHOD (ENACTED IN TEFRA, P.L. 97-248), MEDICARE WILL PAY THE HMO A RATE SET IN ADVANCE AT 95% OF WHAT WOULD HAVE BEEN SPENT TO PROVIDE THE MEDICARE BENEFIT PACKAGE IN THE FEE-FOR-SERVICE SECTOR. FOR THE FIRST TIME, HMO MEDICARE MEMBERS WILL RECEIVE THE BENEFITS OF HMO MEMBERSHIP -- PREDICTABLE, LIMITED OUT OF POCKET EXPENDITURES; NO WORRIES ABOUT LOCATING PROVIDERS WHO ARE WILLING TO ACCEPT ASSIGNMENT, NO CONFUSING PAPERWORK, AND MORE SERVICES FOR THEIR (AND MEDICARE'S) HEALTH CARE DOLLARS. THIS WILL HAPPEN NOT AS THE RESULT OF A FEDERAL LIMIT ON SPENDING, BUT AS THE RESULT OF A FEDERAL INVESTMENT IN A HEALTH CARE DELIVERY MECHANISM THAT PROVIDES INCENTIVES TO CHANGE THE BEHAVIOR OF PROVIDERS AND BENEFICIARIES.

I DO NOT BELIEVE THAT GOVERNMENT CAN EFFECTIVELY MANDATE OR REGULATE BEHAVIOR OF PATIENTS OR PROVIDERS THROUGH PRICE CONTROLS. THE ONLY LONG TERM SOLUTION IS A SET OF INCENTIVES THAT GIVES INDIVIDUALS GREATER RESPONSIBILITY FOR THEIR HEALTH STATUS AND ENCOURAGES PROVIDERS TO FOCUS ON MAINTAINING HEALTH FIRST AND INTERVENING ONLY WHEN NECESSARY.

HMOS ARE NOT THE COMPLETE SOLUTION, HOWEVER. WE DIRECTLY CONTROL COSTS FOR OUR OWN MEMBERS, BUT OUR MODE OF PROVIDING HEALTH CARE HAS AN INDIRECT IMPACT ON THE REST OF THE HEALTH CARE COMMUNITY. STUDIES SHOW THAT THE DEVELOPMENT OF A STRONG PREPAID GROUP PRACTICE OFTEN SPARKS CREATION OF A COMPETING IPA MODEL HMO AND THAT PROVIDERS COMPETING WITH HMOS ARE SPURRED TO REDUCE COSTS BY IMPROVING THEIR OWN PATTERNS OF UTILIZATION.

BUT THE HMO MODEL IS PROVEN AND HMO MEMBERSHIP IS GROWING. HMOS OFFER THE BEST LONG RANGE SOLUTION TO MODERATING INCREASES IN HEALTH SPENDING WHILE IMPROVING THE HEALTH STATUS OF AMERICANS.

HMOS HAVE DEMONSTRATED THAT THROUGH A PREPAID ORGANIZED DELIVERY SYSTEM OFFERING COMPREHENSIVE HEALTH CARE, A COST EFFECTIVE ALLOCATION OF RESOURCES CAN BE ACHIEVED WITHOUT SACRIFICING QUALITY. BY PROVIDING AN ALTERNATIVE TO THE FEE-FOR-SERVICE SYSTEM, WE ARE AN ELEMENT OF COMPETITION IN THE HEALTH CARE MARKETPLACE WHICH CHALLENGES OTHERS TO MATCH OUR ACHIEVEMENTS. ONE EFFECTIVE STRATEGY FOR PROMOTING HEALTH CARE COST CONTAINMENT, THEREFORE, IS TO INSURE THAT HMOS AND OTHER ALTERNATIVE DELIVERY SYSTEMS CONTINUE TO HAVE AN EQUITABLE OPPORTUNITY TO COMPETE.

YOU WILL BE LOOKING AT A VARIETY OF APPROACHES TO HEALTH CARE COST CONTROL. AS YOU CONSIDER THESE APPROACHES, I URGE YOU TO PROTECT THE INCENTIVES THAT ALLOW HMOS TO DEVELOP. FOR EXAMPLE, AS YOU EXAMINE RATE SETTING, YOU SHOULD UNDERSTAND THAT LIMITS ON HOSPITAL COST PER ADMISSION ARE COUNTER-PRODUCTIVE FOR HMOS BECAUSE THEY DO NOT RECOGNIZE WHAT WE DO BEST -- REDUCING THE

LENGTH AND INTENSITY OF A HOSPITAL STAY. FORCING HMOS INTO SUCH A SYSTEM IS A SHORT TERM APPROACH THAT DESTROYS OUR INCENTIVE TO CONTROL HOSPITAL UTILIZATION.

PLEASE ALSO CONSIDER THE OTHER FACTORS THAT LEAD TO INCREASED COSTS IN OUR HEALTH SYSTEM. ONE SUCH FACTOR IS THE SUPPLY OF PHYSICIANS AND HOSPITAL BEDS. THE MORE PHYSICIANS, AND THE MORE HOSPITAL BEDS, THE HIGHER OUR TOTAL SPENDING WILL BE. IN ADDRESSING THE OVERALL ISSUE OF HEALTH CARE COSTS, YOU SHOULD NOT IGNORE THESE CONSIDERATIONS.

FINALLY, DISPITE OUR CONCERN ABOUT COST, I URGE YOU TO KEEP IN MIND THAT OUR PUBLIC PROGRAMS DO AN ENORMOUS AMOUNT OF GOOD. WE HAVE A NATIONAL COMMITMENT TO CONTINUED ACCESS TO CARE FOR THE AGED AND POOR -- AND THIS COMMITTEE HAS AN ESPECIALLY PROUD TRADITION OF SUPPORT FOR THOSE PROGRAMS. WE NEED TO MAINTAIN THAT COMMITMENT. THE CHALLENGE IS TO DO IT MORE EFFECTIVELY.

MR. CHAIRMAN, I THANK YOU FOR THIS OPPORTUNITY TO TESTIFY, AND WOULD BE PLEASED TO ANSWER ANY QUESTIONS THAT YOU MAY HAVE.

Group Health Plan, Inc.
2829 UNIVERSITY AVENUE S.E. MINNEAPOLIS, MN 55414
(612) 623-8400

Group Health Plan

Fact Sheet

Description:	Group Health Plan is the largest prepaid medical care organization in the Midwest. It is nationally recognized as a pioneer among health maintenance organizations and is among the largest in the country.
Area Served:	Seven-county Twin Cities metropolitan area.
Physicians:	More than 190 full-time staff physicians and dentists are among the staff of 1,640 in the Twin Cities area. Other professionals on the staff include nurses, nurse practitioners, surgeon's assistants, nurse-midwives, chemical dependency counselors, social workers, psychologists, nutritionists, health educators, dental assistants, technologists, technicians, pharmacists, optometrists, opticians, administrators and others.
Specialties:	Twenty-five medical specialties and subspecialties are represented on the staff including allergy, behavioral pediatrics, cardiology, dermatology, endocrinology, family practice, gastroenterology, general surgery, hematology, internal medicine, neonatology, neurology, obstetrics and gynecology, oncology, ophthalmology, orthopedic surgery, pediatric cardiology, pediatric hematology, pediatric oncology, pediatrics, psychiatry, pulmonary medicine, reproductive endocrinology, rheumatology, and urology. Dental specialties and supspecialties include endodontics, general dentistry, pedodontics, periodontics, and oral pathology.
Medical Centers:	Twelve in the Twin Cities metropolitan area: Bloomington, Brooklyn Center, St. Louis Park, Maplewood, Plymouth, Spring Lake Park, Apple Valley, White Bear Lake, St. Paul and Minneapolis.
Hospitals Used:	The principal hospitals used are Fairview downtown, the University of Minnesota hospitals, St. Mary's, St. Paul-Ramsey, Minneapolis Children's, Mt. Sinai and Abbott-Northwestern.

Membership: Most members belong through an employer, union or some other type of group. More than 360 groups now offer Group Health Plan. Groups include Sperry-Univac, Northwest Orient Airlines, Northern States Power, The St. Paul Companies, Pickwick International, Westinghouse, K-Mart, Munsingwear, Nabisco and two locals of the International Association of Machinists and Aerospace Workers Union. About 10,000 Group Health Plan members have non-group coverage, rather than membership through a group.

Group Health Plan is the largest HMO in the Twin Cities. More than one out of every three Twin Cities HMO members belongs to Group Health Plan. One out of ten Twin Cities residents is a Group Health Plan member.

Organization: Group Health Plan is owned by its members who elect a 15-member board of directors. It is a non-profit corporation.

Earnings: Net earnings of the corporation are channeled into added benefits. In 1982 Group Health Plan operating revenue was more than $95 million.

Professionalism: Physicians are screened carefully according to rigorous standards. More than 80 percent of the physicians are board certified, which means they have medical education beyond specialty training and have passed extensive examinations in their field. All physicians recruited by the Plan are board-eligible and are expected to become board-certified in order to continue their association with the Plan. Many GHP physicians teach, publish and conduct research. Fifty percent are on the clinical faculty of the University of Minnesota.

Eight medical department heads monitor the quality of care and the performance of each physician.

Group Health Plan, Inc.
2829 UNIVERSITY AVENUE S.E., MINNEAPOLIS, MN 55414
(612) 623-8400

HMOS........

ARE ABLE TO:

1. Offer members comprehensive, high quality care.

2. Manage this care efficiently.
    - By emphasizing preventive health services and health education.
    - By providing the necessary level of care in an appropriate setting.

3. Control hospital utilization.

4. Purchase hospital services in a prudent manner on the basis of quality, access and cost.

5. Control costs for members.

SHOULD NOT BE EXPECTED TO:

Contain system wide health care costs.

- As hospitals seek to maintain revenues by
    - shifting costs
    - enlarging their geographic base
    - diversifying into new services
- As other third party payers struggle to control their costs.

Group Health Plan, Inc.
2829 UNIVERSITY AVENUE S.E. MINNEAPOLIS, MN 55414
(612) 623-8400

HMOS MANAGE CARE EFFICIENTLY

WHERE DO THE DOLLARS GO?:

	INPATIENT SERVICES	OUTPATIENT SERVICES
1976		
HMOS [1]	38%	50%
Minnesota BC/BS [2]	54%	36%
1979		
HMOS	32%	55%
Minnesota BC/BS	53%	37%
1980		
HMOS	31%	57%
Minnesota BC/BS	52%	39%

[1] Minnesota Department of Health

[2] University of Minnesota Center for Health Services Research estimated claims paid.

Group Health Plan, Inc.
2829 UNIVERSITY AVENUE S E MINNEAPOLIS, MN 55414
(612) 623-8400

HMOS CONTROL HOSPITAL UTILIZATION

INPATIENT DAYS PER 1,000 ENROLLEES

YEAR	TOTAL TWIN CITIES [1]	METRO HMOS [2]	RATIO [3]
1978	1,292	466	3:1
1979	1,379	460	3:1
1980	1,407	455	3.1:1
1981	1,328	433	3.1:1
1982	1,248	407	3.1:1

1 Council of Community Hospitals

2 Minnesota Department of Health

3 Ratio of Total Twin Cities to Metro HMOs

Group Health Plan, Inc.
2500 COMO AVENUE ST PAUL MN 55108
(612) 641-3100

1981 UTILIZATION PERFORMANCE

All HMOs (U.S.)	467 inpatient days/1000 members
All Group/Staff/ Network Models	430 days/1000
All IPAs	537 days/1000
Minnesota HMOs	451 days/1000
Minnesota Blue Cross/ Blue Shield (Employed group coverage)	906 days/1000
Minneapolis/St. Paul Community - Wide (includes over 65)	1097 days/1000

Sources: 1981 National HMO Census, Interstudy; and Twin Cities Hospital Utilization and Costs: 1981 Annual Report, COCH.

Average Length of Stay for Major Diagnostic Groups by HMO and Non-HMO Payment Sources: 1978

Diagnostic Group	HMO	Non-HMO	HMO as % of Non-HMO
All diagnoses	5.1	8.2	62
Infectious/Parasitic	4.1	6.0	68
Malignant Neoplasms	7.4	11.7	63
Benign Neoplasms	4.9	5.4	91
Endo/Nutritive/Metabolic	6.9	8.1	85
Blood and Related	6.6	9.5	69
Mental	13.5	19.7	69
Nervous	3.1	5.4	57
Circulatory	8.1	10.4	78
Respiratory	4.2	5.6	75
Digestive	5.8	7.1	82
Genitourinary	3.9	5.8	67
Pregnancy Related	4.0	4.0	100
Skin	4.2	8.6	49
Musculoskeletal	7.9	9.6	82
Congenital Anomalies	3.2	7.8	41
Perinatal Conditions	3.8	9.8	39
Ill-defined Conditions	3.1	6.1	51
Injuries	5.5	8.8	63
Adverse Effects	5.4	6.8	79
Exams/Miscellaneous	2.2	3.9	56
Births/Deliveries	13.0	13.6	96

SOURCE: November 1978 Twin Cities Area Hospital Patient Origin Study, Metropolitan Health Board

Group Health Plan, Inc.
2829 UNIVERSITY AVENUE S.E. MINNEAPOLIS MN 55414
(612) 623-8400

HMOS CONTROL COSTS FOR MEMBERS

	INCREASES IN:	
	HMO COST PER ENROLLEE [1]	PER CAPITA PERSONAL HEALTH CARE EXPENDITURES [2]
1979	7%	12%
1980	13%	15%
1981	12%	15%

---

[1] Minnesota Department of Health

[2] U.S. Health Care Financing Administration

Senator **Percy**. I am very sorry that we are all on a very tight time schedule today, because of other problems that are going on in the city in which we are involved.

I have just 3 or 4 minutes left. I would like to put one question to each of you, and just have a 1-minute rule on it.

First, Mr. Etheredge, it is widely accepted that we need to accept reimbursement for hospitals. Let me be sure I understand what you are saying.

You also think it is going to be necessary to reimburse physicians respectively, if we are going to be serious about controlling hospital costs?

Mr. **Etheredge**. Absolutely. When medicare was established the prevailing method for paying physicians in this country was fee schedules. Medicare adopted a usual, customary, and reasonable charge method; which allowed charges to go up with what physicians billed to insured patients. That has since become the prevalent way of paying physicians in this country.

As a result, we are paying physicians far more for hospital care than for taking care of the same patient out of the hospital. Until we address those incentives for physicians, who are the decisionmakers in this process, I do not think we are going to get a handle on hospital costs. And that means changing the way medicare pays physicians.

Senator **Percy**. Ms. Butler, I was alarmed at the per diem costs that you were talking about. Some time ago, when inflation was a little higher than it is now, I was told by some, that a four-star hotel would be charging, instead of $550 for a small suite, they would be charging, in 10 years, $1,000 a night.

Have you known of any projections that are made 10 years ahead as to what a hospital room would cost overnight?

Ms. **Butler**. I can tell you what health insurance would cost for a family of four for 1 year in 1992. If it goes at the current rate, people will be paying $62,000 a year.

Senator **Percy**. On that happy note, Dr. Cook, it is interesting to hear about yet one more remarkable Rochester achievement. But there is a general sentiment that Rochester can succeed where everyone else fails.

Is the regional hospital reimbursement program different? Can it be successfully transferred to other communities? And if so, how can it be done?

Dr. **Cook**. I think it can be transferred to a large number of other communities. I do not think it admits of a complete generalization.

For example, I do not think it would be easy to install it in Brooklyn, or Manhattan, or some other suburb of a large city.

I tried to outline the reasons that I thought it was successful. And I do not see, inherent in those reasons, any limits on its applicability, apart from the geographic one. And as a practical matter, the State of Maine has considered and modified a bill which was drafted along the lines of the Rochester model.

On the other hand, I would also emphasize that the criticism of the system, or the limitation of the system, as we now see it, is a vital one. And that it is essential in controlling health care costs, to change incentives of the physicians. For that reason, I am very much in support of the observations of Mr. Etheredge and Mr. Schaeffer with regard to the need to do that, if we are going to control health care costs in the long term.

Senator **Percy**. Thank you very much, indeed.

And finally, Mr. Schaeffer, over the next 20 years, how much will the growth of HMO's, PPO's, and other nonregulatory programs be able to contribute to solve medicare trust fund problems?

Mr. **Schaeffer**. It is hard to estimate. But under the new financing enacted by the Congress, I think we will begin to see rapid growth of membership in HMO's and medicare eligibles.

I think in the Twin Cities it is something like over 2,000 members a month enrolling out of medicare eligibility. So my guess would be, there would be a substantial impact over the next decade.

Senator **Percy**. I want to thank all of you very, very much, indeed, for your thoughtful testimony. It was extraordinarily helpful to the committee. And I would like to thank our other panel as well.

We will keep the record open for questions from myself and other Senators to be submitted. And, we will be most interested in the answers.

Being nothing further, this meeting is adjourned.

Thank you.

[Whereupon, at 11:50 a.m., the committee adjourned.]

APPENDIX

STATEMENT OF DEBORAH CHOLLET,* PH. D., RESEARCH ASSOCIATE, EMPLOYEE BENEFIT RESEARCH INSTITUTE, WASHINGTON, D.C.

Mr. Chairman, I appreciate the opportunity to submit this statement for the record. The Employee Benefit Research Institute is a nonprofit, nonpartisan public policy research organization founded in 1978. EBRI sponsors research and educational programs in an effort to provide a sound information basis for public policy decisions. EBRI does not take positions on public policy issues. I am pleased to address the committee concerning employer efforts to control the rising cost of health care in the United States.

Various measures taken by employers to contain the cost of providing health insurance benefits to employees and their dependents have been widely publicized over the last few years. These measures, while designed to serve the narrower goal of controlling employer costs, promise to also serve the broad goal of controlling aggregate health care costs. Neither the prevalence nor the effectiveness of alternative strategies adopted by employers in controlling the cost of their health insurance programs have been documented. No nationally representative data have been compiled that would track recent changes in the design of employer group plans to control plan costs. Nevertheless, we have some evidence that plan design changes as strategies to control plan costs are increasingly frequent; further, these changes may be at least moderately successful in stabilizing employer costs and raising employee awareness of the cost of their health care. Consumer awareness of their own health care costs has often been identified as a critical factor in containing aggregate health care cost inflation. Control of health care cost inflation, in turn, is an important factor in controlling the growing public burden of medicare and medicaid.

The variety of plan design changes that have been adopted by employers can be grouped into three categories: (1) Changes that are intended to redirect employee incentives to use health care in general, and hospital care in particular; (2) changes that specifically restrict the use of some services; and (3) changes that restructure the delivery of health care services to persons covered under the plan. Changes in the first group, those that redirect employee incentives to use health care services, include imposing higher deductibles and copayments for all or some services covered by the plan, as well as expansion of the scope of covered services to include substitutes for more costly inpatient hospital care. Changes in the second group, those that restrict the use of services covered by the plan, include requiring compliance with formal review of hospital utilization, as well as second-opinion surgery requirements and same-day surgery requirements. Changes in the last group, those that restructure service delivery to persons covered by the plan, include principally the establishment of a "preferred provider" for services covered by the plan. The changes in plan design in each group are discussed in detail below.

In addition to these changes within the framework of existing employer health insurance plans, some employers have initiated a much more sweeping reorganization of their health insurance benefits. In some cases, this reorganization involves simply the offering of more than one health insurance plan option to employees with the same employer contribution to health insurance coverage under each plan option. Other employers have more fundamentally reorganized their health insurance plans within the framework of a flexible benefits program or "cafeteria plan." The incentives for employees to reduce health insurance coverage in favor of greater cost sharing within the context of a flexible benefits program are promising. Most employers who have adopted flexible benefits plans have done so to induce employees to share more of their health insurance costs and to take greater responsibility for controlling those costs. The emergence of flexible benefits plans, and the legal and regulatory impediments to their development, are described briefly below. The statement concludes with an examination of existing evidence on the success of alternative measures adopted by employers to control the cost of their own health insurance plans and, at the same time, the national cost of health care.

---

* The views expressed in this statement are those of the author and do not necessarily reflect the views of the Employee Research Institute, its trustees, members, or other staff.

CHANGING INCENTIVES

Plan design changes that redirect consumer incentives to use health care services include raising the level of cost sharing required by the plan and changes in the scope of covered services. Increased cost sharing under employer group plans may be achieved by raising deductibles and copayments for all or some services covered by the plan, as well as raising employee contributions for their own coverage or for dependents' coverage under the plan. Because these changes reduce employees' real level of compensation by raising their out-of-pocket cost of health care, they have been generally resisted by employees, particularly by those with collectively bargained health insurance plans.

In spite of employee resistance to greater cost sharing, many employers report having raised the deductible or copayment provisions of their group health plan coverage since 1980. One survey of 1,420 employers throughout the United States indicated that approximately one-third (34 percent) had increased the copayment required for coverage of inpatient hospital care.[1] Another survey of 308 large employers indicated that more than half (53 percent) had increased their plans' deductible; 25 percent had increased the copayments required by the plan. In addition, nearly one-third (31 percent) had raised the employee contribution for either their own coverage or dependents' coverage under the plan.[2]

A corollary of increased deductibles and copayment provisions for hospital care has been the reduction of "first-dollar" coverage for inpatient hospital expenses. An annual survey of new comprehensive major medical plans underwritten by 33 major insurers in the United States indicated a sharp reduction in the proportion of new plans that cover initial expenses for inpatient hospital or surgical care.[3] In 1982, only 7 percent of all new plans (weighted by plan size) provided first-dollar hospital/surgical coverage. This rate represents an 81-percent drop since 1980 in the (weight-

TABLE 1.—DISTRIBUTION OF EMPLOYEES BY FIRST-DOLLAR COVERAGE OF HOSPITAL-SURGICAL EXPENSES, NEW COMPREHENSIVE MAJOR MEDICAL PLANS, 1980–82 [1]

[In percent]

Level of coverage	1980	1981	1982	Change, 1980–82
All employees	100.0	100.0	100.0	
First-dollar coverage [2]	36.4	24.4	6.6	−81.0
Deductible or first-dollar copayment	63.6	75.6	93.4	+46.9

[1] Includes new comprehensive major medical plans with hospital room and board coverage only, ancillary hospital service coverage only, all hospital service coverage only, surgical coverage only, or all hospital plus surgical coverage. Surgical coverage may include coverage of either schedule or actual charges.

[2] Plans that provide first-dollar hospital-surgical coverage require no deductible for coverage of hospital or surgical care and no copayment on initial expenses for these services.

Source: Health Insurance Institute, "New Group Health Insurance Policies Issued in 1980" (complete tables), mimeo, table 45; Health Insurance Association of America, "New Group Health Insurance Policies Issued in 1981" (complete tables), mimeo, table 49; Health Insurance Association of America, "New Group Health Insurance Policies Issued in 1982" (complete tables), mimeo, table 50.

---

[1] The 1982 survey of health care cost-containment efforts conducted by William M. Mercer, Inc., is an industry survey, and was not designed to be nationally representative. More than 55 percent of Mercer's respondents were employee groups of more than 1,000 workers.

[2] National Association of Employers for Health Care Alternatives (NAEHCA), "Survey of National Corporations on Health Care Cost Containment" (1982). This survey, like the Mercer survey, is a specialized survey of large firms and was not designed to be nationally representative. The average size of firms that responded to NAEHCA's survey was about 30,000 employees; the smallest respondent employed 100 workers. 1979 information from NAEHCA is obtained from their 1979 Survey of National Corporations on Health Care Costs and Health Maintenance Organizations. The 1979 survey included 251 large employers.

[3] Health Insurance Association of America (HIAA), "New Group Health Insurance Policies Issued in 1982" (complete tables), mimeo (1983).

ed) number of new plans that provide first-dollar coverage for inpatient hospital or surgical care. The annual change in the proportion of new plans providing first-dollar hospital/surgical coverage since 1980 is presented in table 1 on page 9.

Changes in the scope of services covered by the plan are often designed to redirect patient use of health services toward less expensive substitutes for inpatient hospital care. Consistent with this goal, employers are increasingly expanding the scope of group health plans to include coverage of home health care services, hospice services, and outpatient hospital services. Outpatient hospital services covered by employer group plans often include preadmission testing, outpatient surgery, or surgery performed in freestanding surgical centers. These services are often intended to discourage the use of inpatient hospital care or to discourage protracted hospital stays by equalizing insurance incentives between inpatient and outpatient care.

The HIAA survey of new comprehensive major medical coverage described above indicates emerging coverage of services that substitute for inpatient hospital care. In 1982, 89 percent of all new major medical plans (weighted by plan size) covered preadmission testing; 81 percent covered home health care services. Coverage of paramedical testing and hospice care was somewhat less common (44 and 13 percent, respectively). Evidence from other surveys of employers (in particular, the 1980 and 1982 surveys conducted by NAEHCA) indicate that these coverages have become much more common features of employer group plans since 1979.

RESTRICTING SERVICE USE

Restrictions on benefits for the purpose of controlling health plans costs most often apply to the use of inpatient hospital care by plan participants. Restrictions on benefits covered by the plan may include: (1) Compliance with hospital utilization reviews; (2) requirement of a second or third physician opinion before undergoing elective surgery; and (3) same-day surgery provisions. Although many employers have adopted these restrictions, restricting the use of benefits covered by the plan appears to be less popular than increased cost sharing as a method of controlling plan costs.

Hospital utilization review involves assessing the appropriateness of hospital admission, inpatient hospital services, and hospital discharge. Individual employers or insurers may contract with professional service review organizations (PSRO's) or with peer review organizations (PRO's) to evaluate hospital use. Hospital utilization review may be conducted prospectively (before hospital admission), concurrently (during the patient's hospital stay), or retrospectively (after hospital discharge). Because prospective and concurrent review are highly labor intensive and, therefore, costly to produce, review organizations often delegate prospective and concurrent review to the admitting hospital on a subcontract basis. Critics of the utilization review process, however, have charged that the practice of delegating review to the hospitals significantly compromises its effectiveness. As a result, employers who use utilization review most often use retrospective review. Although retrospective review itself does not limit benefits covered by the plan, it may enable the plan to enforce other plan restrictions on coverage prior to payment. Retrospective review probably also exerts a "sentinel" effect on plan participants, physicians, and hospitals, particularly when the employer or insurer is large and well known to local health care providers. The 1982 NAEHCA survey of employers indicated that 35 percent of the surveyed employers used utilization review; this rate was 10 percent greater than the 1979 rate reported in NAEHCA's earlier survey.

Plan provisions that require a second or third medical opinion before elective surgery are often enforced either by refusing payment for failure by plan participants to comply, or by imposing a separate deductible or higher copayment for expenses related to the surgery. Same-day surgery provisions are intended to eliminate unnecessarily early hospital admissions and the subsequent higher cost of hospital room and board. This provision may uniformly exclude coverage of hospital room and board charges for weekend admissions unless surgery is scheduled for the following morning. To date, no surgery information has tracked the emergence of same-day surgery provisions in employer group health plans. Second- or third-opinion surgery provisions, however, have become quite common. The 1982 HIAA survey of new comprehensive major medical plans underwritten by major insurers indicated that 84 percent of plans (weighted by plan size) included a second-opinion surgery provision.

RESTRUCTURING SERVICE DELIVERY

The emergence of contractual arrangements between individual providers or provider groups and some employers or insurers is an important development in the effort to control health care costs. These arrangements have come to be known generically as preferred provider organizations (PPO's). A PPO is a contractual arrangement between providers and purchasers of health care services. Under the arrangement, providers may agree to discount charges in return for guaranteed prompt payment. In addition, providers may cooperate in utilization review that would monitor and contain the growth of health service use and plan costs. As an incentive for plan participants to use the services of the PPO, plan coverage is often better for PPO services than for services delivered by other providers. Greater coverage for PPO services might be achieved by waiving the deductibles, copayments, or limits on coverage for services delivered by the PPO.

The legal status of preferred provider organizations has been an important obstacle to their development. Several forms of these arrangements have been found in violation of antitrust laws as horizontal price-fixing arrangements (*Arizona* v. *Maricopa County Medical Society,* 1982) or as arrangements potentially in restraint of trade (*Group Life and Health Insurance Company* v. *Royal Drug Company,* 1979). In general, a PPO is open to legal review; nevertheless, these arrangements have been pursued aggressively by some employers and insurers in an effort to control the cost of their group health insurance plans.

THE EMERGENCE OF FLEXIBLE BENEFIT PLANS

A flexible benefit or "cafeteria" plan is an employer benefits plan which gives employees some choice among types of benefits or relative amounts of benefits provided by the employer. Plans established under Internal Revenue Service Code, section 125, may not contain a pension plan or other deferred income plan other than an employee profit-sharing plan. To the extent that a "typical" flexible benefits plan exists, these plans typically include two or more health insurance plans. They may also include a dental insurance plan, group life and disability insurance, dependent care benefits, group legal services, vacation and sick leave time, and a cash account—sometimes called a "reimbursement account"—from which employees may reimburse themselves for out-of-pocket health care expenditures, or contribute to a savings plan on a pretax basis. IRS Code, section 125, was legislated in 1978; implementing regulations, however, have not been issued by the Department of the Treasury. Despite the resulting atmosphere of uncertainty, the popularity of flexible benefits programs among both employers and employees has generated apparently significant growth of these plans during the last 5 years.

Employer goals in implementing a flexible benefits program are complex. Often they include:

Containing the cost of group health insurance benefits by inducing employees to share more of the health care costs covered by the plan;

Offering employees new, specialized benefits tailored to the needs of a demographically changing work force without substantially raising total benefits costs; and

Encouraging employees to elect higher levels of saving, anticipating the need for greater reliance on personal savings for retirement income.

The inclusion of a cash reimbursement account in these plans is often, in the employer's mind, critical to the success of the program in reducing health plan costs. Employers anticipate that employees would resist "trading down" to a less generous health insurance plan option in the absence of an ability to, in effect, insure against unanticipated out-of-pocket expenses. A reimbursement account enables employees to self-insure against higher health insurance costs; the employee can designate residual balances in the reimbursement account to pretax saving (possibly in a 401(k) account), or cash the account out as taxable earnings.

Employers anticipate reducing their health insurance benefits costs, and reducing total employee health care expenses, by fixing their contribution to health insurance benefits. Employer contributions can be fixed either absolutely or as a percentage of the cost of the lowest cost health insurance plan. Employees have an incentive to use fewer health care services, even with a cash reimbursement account. Dollars taken to reimburse employees for the initial costs of their health care—those not covered by the less generous health insurance plan they have elected—reduce their ability to purchase other benefit options, contribute to pretax savings, or receive additional cash income.

The repricing of alternative health insurance plan options in a flexible benefits program—consistent with the cost experience of the plans—is important to the program's potential success in containing health insurance costs and health care costs aggregately. Employers who provide more than one health insurance plan option anticipate "adverse selection" by employees. That is, employees who expect to have lower health care expenditures over the year are most likely to elect a low-cost, less generous health insurance plan. As a result of this adverse selection behavior, employees remaining in the most generous—and most costly—health insurance plan option are likely to represent greater health care costs, on average, than employees who elect a less generous health plan. As a result, the average cost of the most generous plan option is likely to rise significantly faster than the average cost of the least generous plan option. Repricing plan options according to experience will, subsequently, result in the prices of the plans diverging over time.

Employers are concerned that the Tax Code that now governs flexible benefits plans will ultimately limit the repricing of health insurance options according to experience. That is, the nondiscrimination rules that govern flexible benefits under the IRS Code, section 125(g)(2), require employers to contribute not less than 75 percent of the cost of the most expensive health plan to the health plans of all employees. The purpose of this restriction is to prevent employers from offering "luxury" plans to highly compensated employees that are not accessible to lower paid employees. Employers who seek to reduce their health plan costs—and health care costs aggregately—through a flexible benefits program, however, are concerned that this section of the Tax Code restricts their ability to induce employees away from generous health insurance coverage. This concern persists in spite of general employer agreement that the intent of the code with respect to nondiscriminatory benefits is worthy.

THE EFFECTIVENESS OF PLAN REDESIGN

Evidence of the effectiveness of alternative plan design changes is scarce. Most research that has been conducted has examined the effect of greater cost sharing on health service utilization and, subsequently, on hospital costs. This research has uniformly concluded that higher cost sharing by insured consumers reduces the use of health care services, including the use of inpatient hospital care. It appears that reduced use of hospital care, and lower hospital costs, result from significantly lower rates of hospital admission among persons with insurance that requires greater cost sharing for hospital expenses.[4] Whether increased cost sharing is more effective in containing health plan costs than alternative plan design strategies, however, has received little attention.

The data collected in the 1982 NAEHCA survey of employers allow a preliminary assessment of the relative effectiveness of alternative changes in plan design intended to control health care costs. By inference, strategies that are effective in reducing employers' costs of providing health insurance benefits are also effective in reducing aggregate health care utilization and cost. The magnitude of that saving, however, cannot be measured with available survey data.

The information provided by the NAEHCA survey, moreover, must be considered with caution. These data provide the only published assessment of the relative effectiveness of the various cost-control strategies that have been adopted by employers. Nevertheless, the published distributions provide no information about the combinations of strategies used by employers. The particularly good cost experience associated with any particular strategy, therefore, may reflect the usual adoption of that strategy in combination with other measures to control health care costs.

Despite this problem, the results reported in the NAEHCA survey are reasonable. These results are summarized in table 2. Among respondents that had added or increased the copayments required by the plan, 70 percent had experienced cost increases that were less than the median cost increase reported by all respondents. Similarly, coverage of hospice benefits was associated with good cost experience; the narrow margin between the cost experience of employers whose health insurance plans covered hospice care and those whose plan did not probably reflects the low frequency of terminal illness and hospice use even among plans that continue health insurance coverage to retirees.

---

[4] See, for example, the results reported by J. P. Newhouse, et al., "Some Interim Results From a Controlled Trial of Cost Sharing in Health Insurance," The New England Journal of Medicine 305, No. 25: 1501-1507.

TABLE 2.—PROPORTION OF RESPONDENTS WHO EXPERIENCED COST INCREASES BELOW THE SURVEY MEDIAN INCREASE IN 1981 BY WHETHER THEY IMPLEMENTED A SPECIFIC PLAN FEATURE

[In percent]

Program	Have implemented	Have not implemented	Difference
Added or increased amount of coinsurance	70.0	32.1	37.9
Covered hospice benefits	60.0	54.4	5.6
Used outpatient review	58.3	46.2	12.1
Covered outpatient surgery or surgical centers	52.5	27.3	25.2
Covered home health care	52.2	38.5	13.7
Used inpatient review	50.8	45.5	5.3
Implemented a health promotion program	50.7	47.3	3.4
Required a second surgical opinion	50.4	47.2	3.2
Used coordination of benefits	49.3	40.0	9.3
Used claims review	49.1	47.9	1.2
Covered preadmission testing	48.3	42.1	6.2
Covered extended care facilities	47.7	39.3	8.4
Increased deductibles	40.1	44.9	−4.8
Increased amount employee pays of premium	26.1	49.0	−22.0
Added an optional low-benefit plan	12.5	48.4	−35.9

Source: W. Pollock and R. H. Stack, "1982 Survey of National Corporations on National Corporations on Health Care Cost Containment," National Association of Employers on Health Care Alternatives (1983): pp. 29–31.

Raising deductibles or the level of employee contribution to the plan have apparently been less successful strategies for controlling health plan costs. The lack of success in achieving lower plan costs through higher deductibles or employee contributions may reflect increases that have been minor relative to either the rising cost of the health plan or to general rates of inflation. Alternatively, employers who have raised deductibles or employee contributions may have done so in order to avoid implementing other plan changes that would reduce health service utilization or redirect patient care to less expensive forms or sources of care. The poor cost experience of employers who adopted optional low-benefit plans may reflect adverse selection and a rapid increase in the cost of the more generous plan; the data do not indicate whether the multiple plans were offered in the context of a flexible benefits program, or whether other incentives were provided for employees to elect less generous health insurance coverage.

SUMMARY

Although changes initiated in employer group health plan design over the last few years have received considerable media attention, no nationally representative data have been collected to document those changes. We have no good evidence, moreover, that the changes that employers have initiated in the design of their health insurance plans have been effective—alone or in combination with other efforts—in controlling either plan costs, or the total cost of health care among employees. In general, the changes that have occurred are too new to evaluate their effectiveness. Nevertheless, preliminary evidence has begun to emerge; this statement provides a summary of available evidence regarding the effectiveness of alternative employer strategies to control health care costs.

The changes initiated by employers include: (1) Changes intended to encourage employees to use less health care and to use less expensive forms of health care; (2) changes that restrict the use of health care services covered by the plan; and (3) changes that encourage employees to obtain services from providers that have contracted to provide a discount from normal charges, or more importantly, to cooperate with utilization review. Although the prevalence of these changes has been documented only by industry survey data—none of which were intended to be nationally representative—these surveys suggest that employers have been aggressive in their pursuit of strategies to control the cost of their health plans by inducing employees to be more aware of their own health care costs. Many who would reform the health care delivery system in the United States see the lack of consumer awareness of health care costs as a critical source of health care cost inflation. Survey evidence suggests that health care cost inflation itself has forced employers to consider dramatic changes in their health insurance benefits. These changes may be the single most promising avenue for controlling the rising cost of health care for all payers.

The changes initiated by employers are notable for two reasons. First, they have occurred in a relatively undramatic, incremental fashion—and without legislation that would either encourage or require change. In fact, employers have implemented both preferred provider organizations (PPO's) and flexible benefits programs in spite of potential conflicts with existing law.

Second, these changes reflect the real options available to employers and private insurers in controlling health care costs. Other potential strategies—such as the implementation of prospective pricing for services delivered to plan participants—are often unfeasible in a competitive environment. It is likely that prospective pricing by a single small plan would merely lower the value of health insurance coverage to plan participants and restrict their access to health care. Neither employers nor insurers are able to require providers to accept prospective payment as payment in full, as does both medicare and medicaid. It is important that employer actions to control health care costs be evaluated in the context of the competitive environment in which employee health benefits and health insurance contracts are bargained.

I thank you for the opportunity to submit this statement, and stand ready to assist the committee in further consideration of measures to control the rising cost of health care.

○